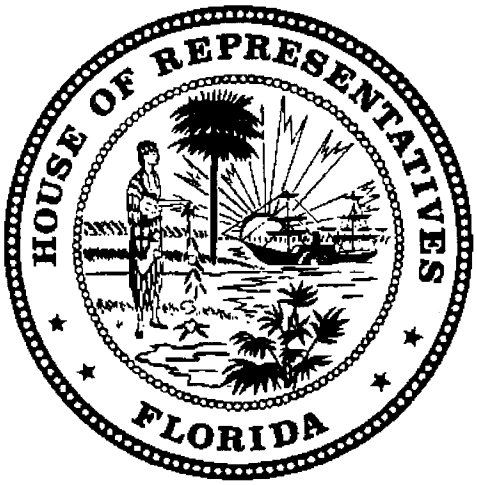


Health Care Regulation Committee

Wednesday, January 11, 2006
10:45 AM - 11:45 AM
212 Knott Building

Allan G. Bense
Speaker

Rene Garcia
Chair

House of Representatives

Committee on Health Care Regulation

AGENDA

January 11, 2006
10:45 AM - 11:45 AM
212 Knott Building

I. Opening Remarks by Chair Garcia

II. Presentations on Public Safety

Florida Patient Safety Corporation

Introduction by:

Susan A. Moore, Executive Director
Florida Patient Safety Corporation, Tallahassee

John Montgomery, MD
Vice President, Senior Solutions
Blue Cross/Blue Shield Florida, Jacksonville

Florida Hospital Association

Introduction by:

Kathy Holzer, Vice President of Health Policy
Florida Hospital Association, Tallahassee

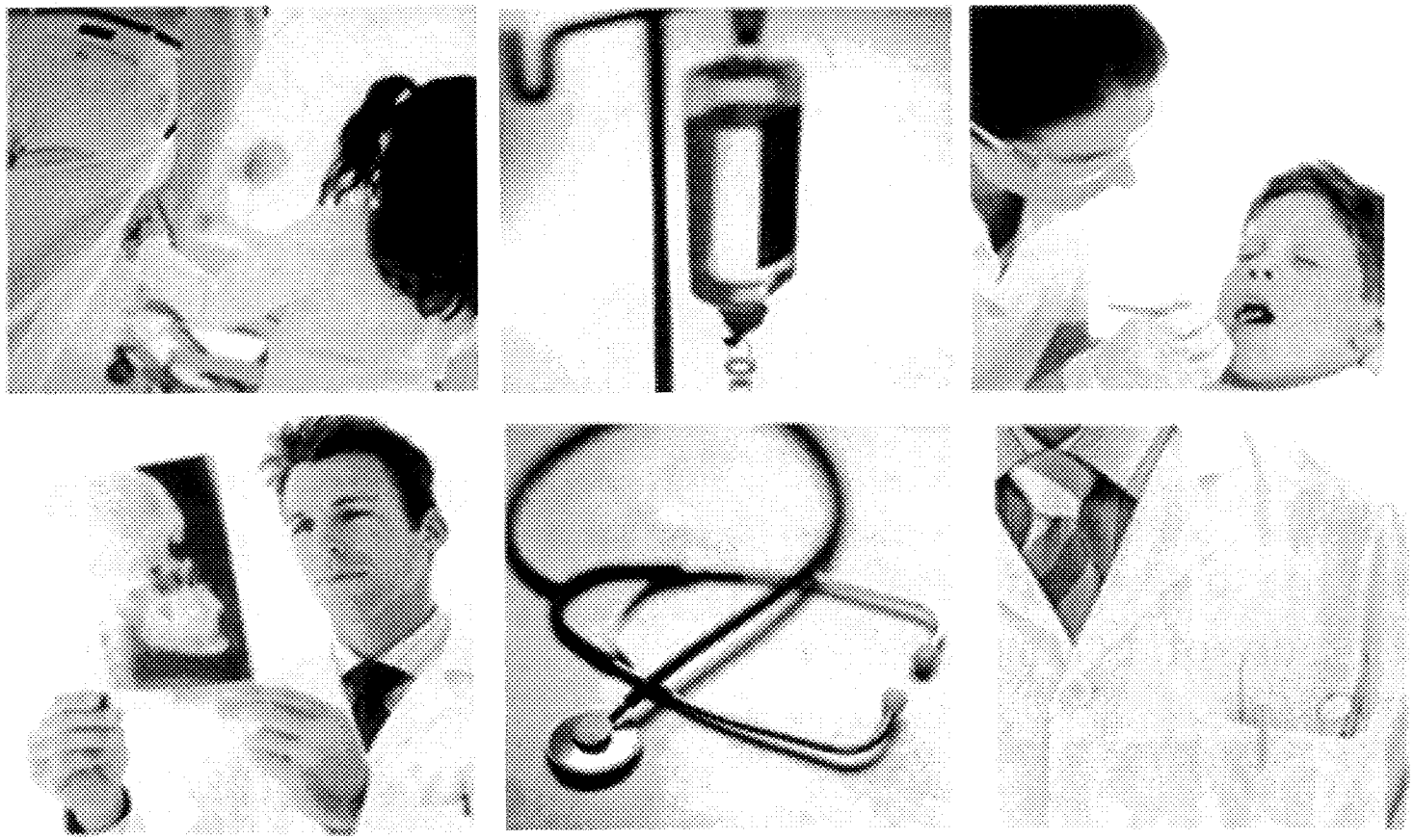
JoAnne Plumlee, RN, MSN
Interim CNO/Patient Safety Officer
Kendall Regional Medical Center, Miami

L. Craig Miller, MD
Senior Vice President/Chief Medical Officer
Baptist Health Care, Pensacola

III. Closing Remarks by Chair Garcia

IV. Adjournment

Florida Patient Safety
Corporation

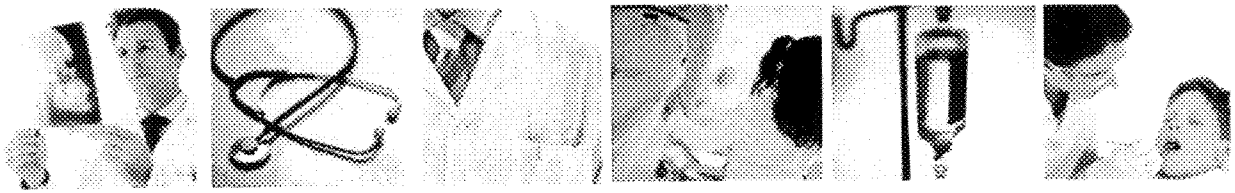


Florida Patient Safety Corporation

www.floridapatientsafetycorp.com

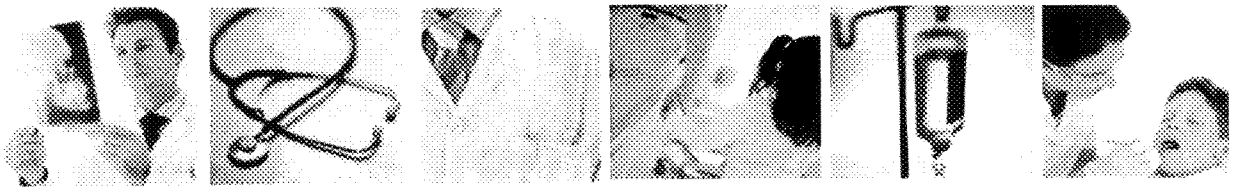
Florida: a Leader in Patient Safety

- Current focus on patient safety is generally attributed to the 1999 publication of ***To Err is Human*** by the Institute of Medicine.
- Florida has established itself as a leader among states in **prioritizing patient safety efforts**.
- A recent report by the National Academy of State Health Policy shows that Florida has created one of the most **comprehensive models** for its patient safety organization.



Impact of Medical Errors

- 44,000-98,000 annual deaths nationally as a result of errors
- Medical errors are the leading cause followed by surgical mistakes and complications
- More Americans die from medical errors than from breast cancer, AIDS or car accidents
- 2% of admissions to hospitals experience an adverse drug event
- 7 % of hospital patients experience a serious medication error



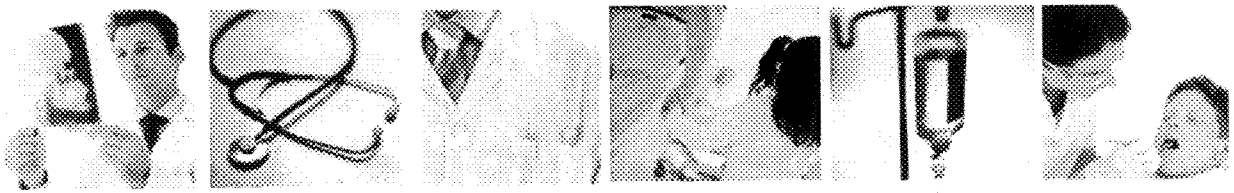
Commission on Excellence in Health Care – 2000 Legislature

- 2000 Legislature passed the **Patient Protection Act of 2000**, which created the **Commission on Excellence in Health Care.**

- Commission representatives came from health care agencies, associations and organizations, medical malpractice professional liability insurance industry, the health insurance industry, attorneys and legislators.

Commission's Recommendation

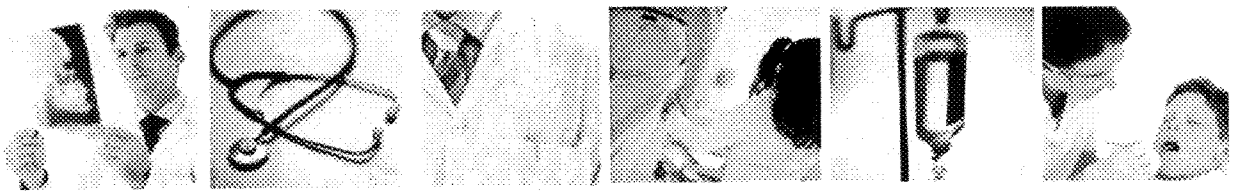
- recommendations included a call for the creation of a separate, **freestanding Center for Patient Safety and Excellence in Health Care.**



Select Task Force on Health Care Professional Liability Insurance 2002

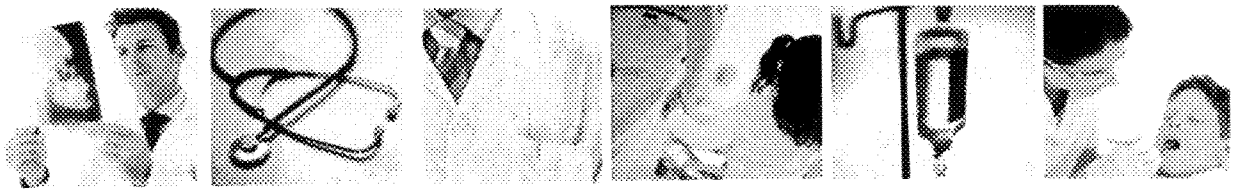
- created in 2002 to:
  - address skyrocketing liability insurance premiums
  - recommend to the Governor and Legislature how to improve the situation

- report included over 60 legislative recommendations including:
  - **legislative creation of a patient safety authority**



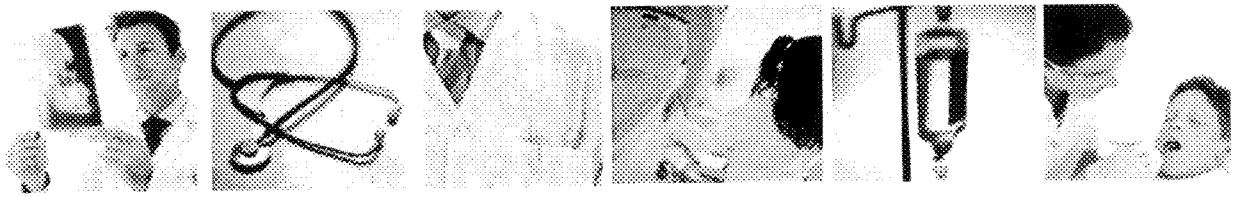
2003 Legislation included Task Force Recommendations

- legislation aimed at improving patient safety:
  - health care facilities must have a **patient safety system and plan**, including a **patient safety officer and committee**
  - patients must be **notified in person** by the facility or licensed health care practitioner in the event of harm
  - licensed health care practitioners must have **patient safety continuing education**
  - AHCA, with the Department of Health and the state's universities' patient safety centers, report on implementation requirements for a **statewide patient safety authority.**
  - report delivered to the Governor and Legislature on **February 1, 2004.**



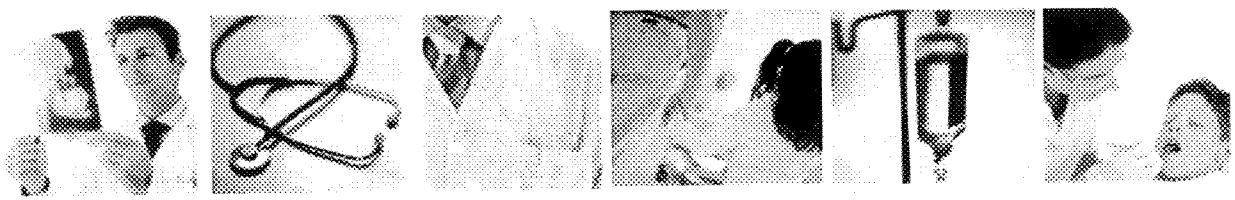
2004 Legislature

- The 2004 legislature followed up on the report recommendations by enacting HB 1629 (Chapter 2004-297, *Laws of Florida*), which established the **Florida Patient Safety Corporation**.



Creation of the Florida Patient Safety Corporation (FPSC)

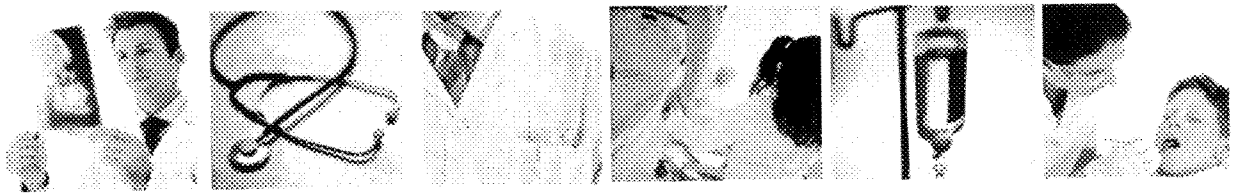
- Created under Section 381.0271, Florida Statutes
- **not-for-profit** corporation
- may create not-for-profit corporate subsidiaries
- subject to the **public meetings and records requirements** of s. 24, Art. I of the State Constitution, chapter 119, and s. 286.011.



Purpose

Although ***the Florida Patient Safety Corporation shall <u>not</u> regulate health care providers in this state,*** it will:

- serve as a **learning organization**
- assist health care providers to **improve the quality and safety** of health care and **reduce harm** to patients
- work with a **consortium of patient safety centers** and other patient safety programs

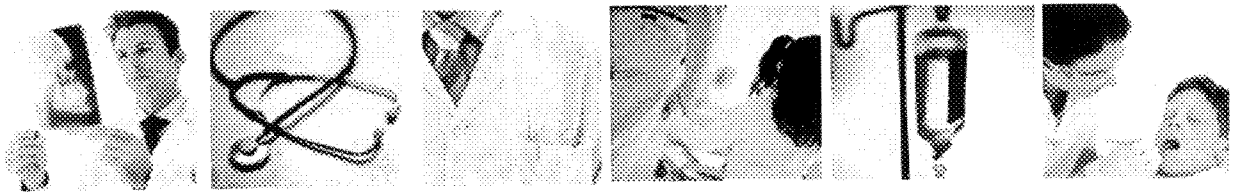


Board of Directors – shall consist of:

(a) The chair of the **Florida Council of Medical School Deans**.

(b) Two representatives with expertise in patient safety issues for the authorized health insurer and authorized health maintenance organization with the largest market shares, respectively, as measured by premiums written in the state for the most recent calendar year, appointed by such insurer.

(c) A representative of an authorized medical malpractice insurer appointed by the **Florida Insurance Council.**

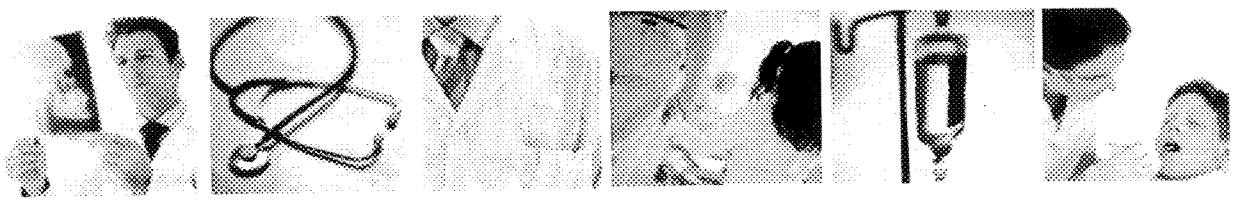


FPSC Board *con't*

(d) The president of the **Central Florida Health Care Coalition.**

(e) Two representatives of a hospital in this state that is implementing innovative patient safety initiatives, appointed by the **Florida Hospital Association**.

(f) A physician with expertise in patient safety, appointed by the **Florida Medical Association**.

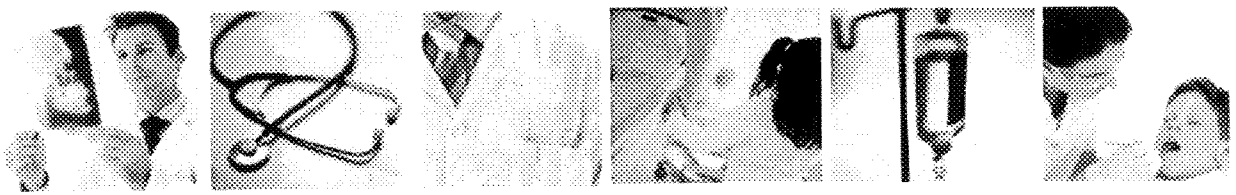


FPSC Board *con't*

(g) A physician with expertise in patient safety, appointed by the **Florida Osteopathic Medical Association.**

(h) A physician with expertise in patient safety, appointed by the **Florida Podiatric Medical Association.**

(i) A physician with expertise in patient safety, appointed by the **Florida Chiropractic Association**.



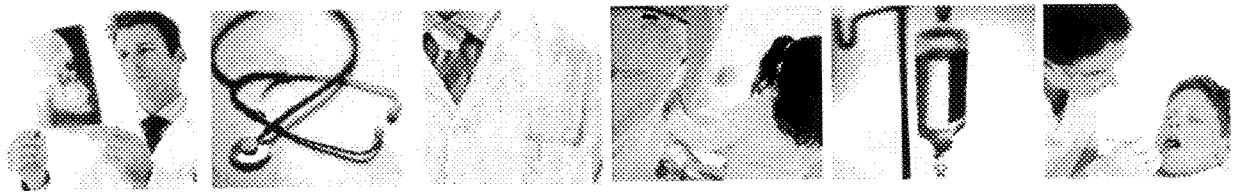
FPSC Board *con't*

(j) A dentist with expertise in patient safety, appointed by the **Florida Dental Association**.

(k) A nurse with expertise in patient safety, appointed by the **Florida Nurses Association**.

(l) An institutional pharmacist, appointed by the **Florida Society of Health-System Pharmacists**.

(m) A representative of **Florida AARP**, appointed by the state director of Florida AARP.

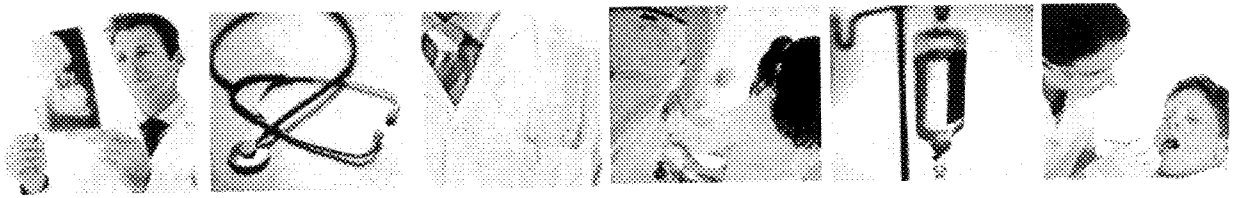


2006 FPSC Board of Directors

Becky J. Cherney	*Florida Health Care Coalition*
James A. Cruickshank	*Florida Hospital Association*
Matthew M. Davies	*United Healthcare*
Michael Redmond, MD	*Florida Medical Association*
Robert A. Iannacone, DPM	*Florida Podiatric Medical Association*
Daniel B. Lestage, MD	*Blue Cross and Blue Shield*
Bentley Lipscomb, **FPSC Vice Chair**	*AARP*
Edward Joseph Meszaros, DMD	*Florida Dental Association*
Risa Rahm, PharmD	*Florida Society of Health System Pharmacists, Inc.*
Clifford G. Rapp	*Florida Insurance Council, Inc.*
Joel B. Rose, DO	*Florida Osteopathic Medical Association*
Thomas M. Rozek, **FPSC Chair**	*Florida Hospital Association*
Anthony J. Silvagni, DO, **FPSC Treasurer**	*Florida Council of Medical School Deans*
Susan White, RN, PhD, **FPSC Secretary**	*Florida Nurses Association*
Wayne Wolfson, D.C.	*Florida Chiropractic Association*

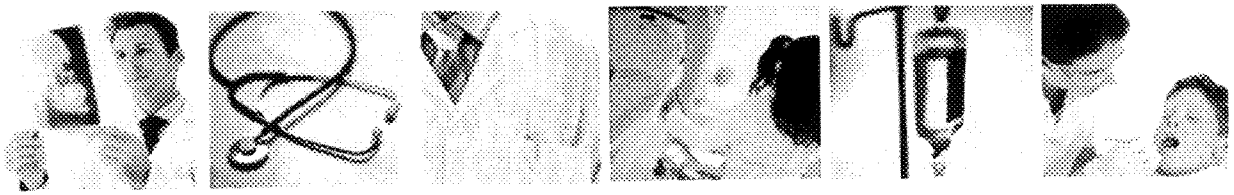
EXECUTIVE COMMITTEE MEMBERS

Chairman:	Thomas M. Rozek
Vice Chairman:	Bentley Lipscomb
Secretary:	Susan White, RN, PhD
Treasurer:	Anthony J. Silvagni, DO,
Member–at-Large:	Michael Redmond, MD



FPSC Staff:

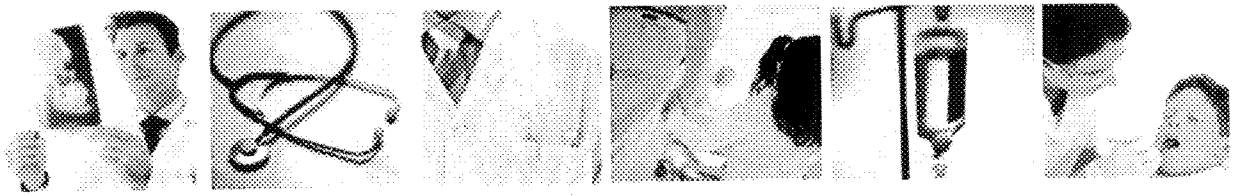
Executive Director – Susan A. Moore, through a management contract with Horizon Healthcare Network



Advisory Committees:

In addition to any committees that the corporation may establish, the corporation is required under its enabling legislation to establish the following **7 advisory committees**:

- **Scientific Research Advisory Committee**
- **Technology Advisory Committee**
- **Health Care Provider Committee**
- **Health Care Consumer Committee**
- **State Agency Advisory Committee**
- **Litigation Alternatives Committee**
- **Education Advisory Committee**

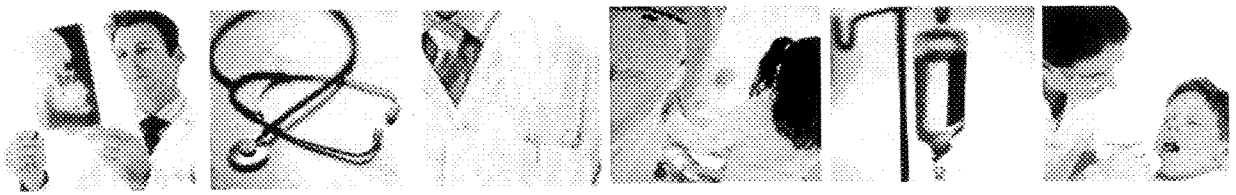


Scientific Research Advisory Committee

Chair: Michael Redmond, MD

Shall include:

- a representative from each patient safety center or other patient safety program in the universities of the state who are physicians licensed pursuant to chapter 458 or chapter 459, with experience in patient safety and evidenced-based medicine.
- **duties** shall include the analysis of existing data and research to improve patient safety and encourage evidence-based medicine.

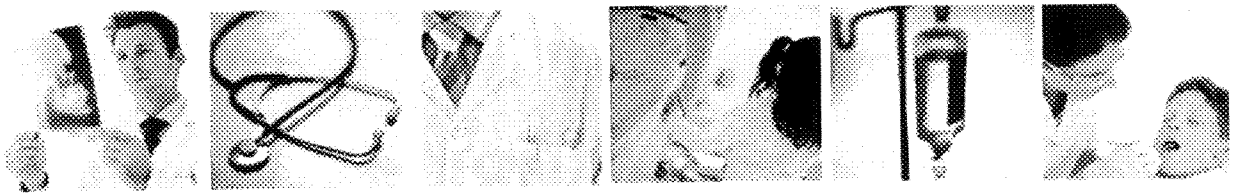


Technology Advisory Committee

Chair: Edward Meszaros, DMD

Shall include:

- a representative of a hospital that has implemented a **computerized physician order entry system**
- a health care provider that has implemented an **electronic medical records** system.
- **duties** shall include, but not be limited to, implementation of new technologies, including electronic medical records.

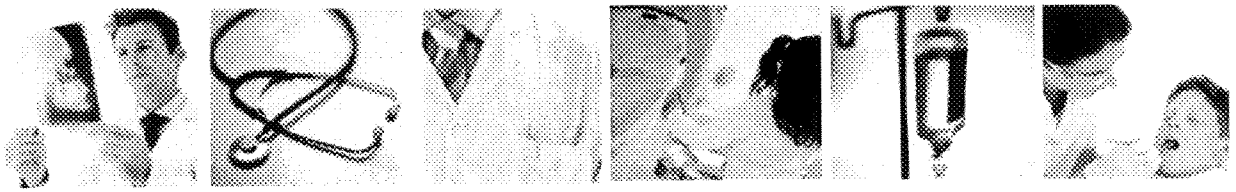


Health Care Provider Advisory Committee

Chair: James A. Cruickshank

Shall include:

- representatives of **hospitals, ambulatory surgical centers, physicians, nurses, and pharmacists** licensed in this state
- a representative of the **Veterans Integrated Service Network 8**, VA Patient Safety Center.
- **duties** shall include promotion of a culture of patient safety that reduces errors.

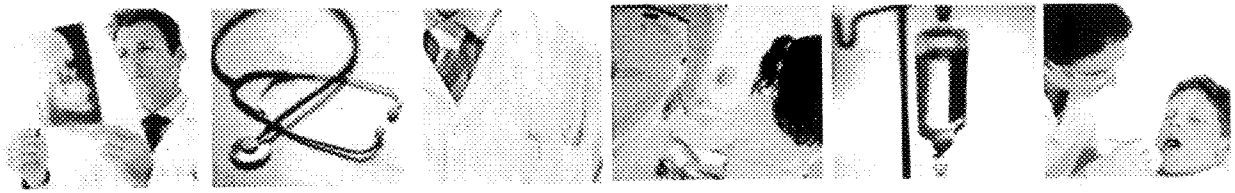


Health Care Consumer Advisory Committee

Chair: Bentley Lipscomb

Shall include:

- representatives of **businesses** that provide health insurance coverage to their employees, **consumer advocacy groups**, and representatives of **patient safety organizations**.
- **duties** shall include incentives to encourage patient safety and the efficiency and quality of care.

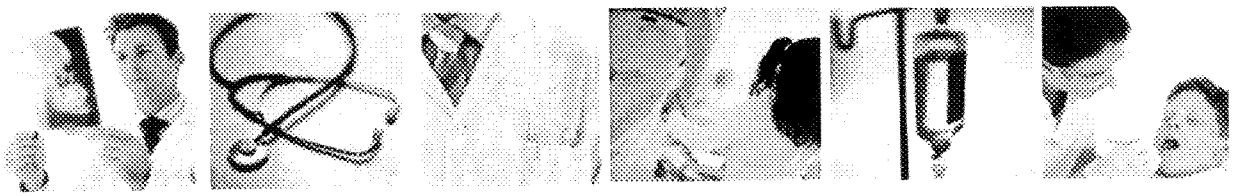


State Agency Advisory Committee

Chair: Joel B. Rose, DO

Shall include:

- a representative from each **state agency** that has regulatory responsibilities related to patient safety.
- **duties** shall include interagency coordination of patient safety efforts.

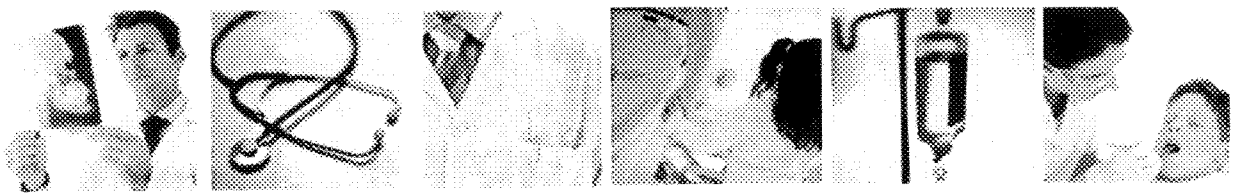


Litigation Alternatives Advisory Committee

Chair: Robert A. Iannacone, DPM

Shall include:

- representatives of **medical malpractice attorneys** for plaintiffs and defendants
- a representative of each **law school** in the state.
- **duties** shall include identifying alternative systems to compensate for injuries.

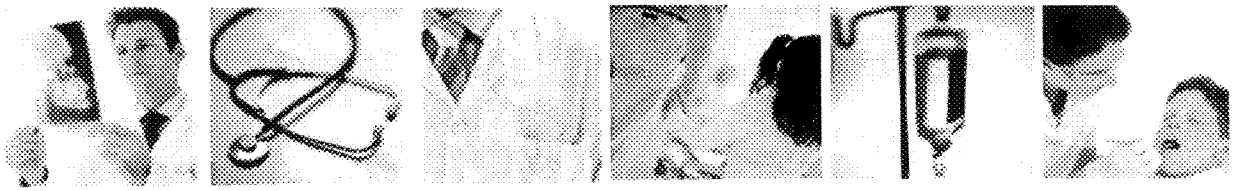


Education Advisory Committee

Chair: Anthony J. Silvagni, DO

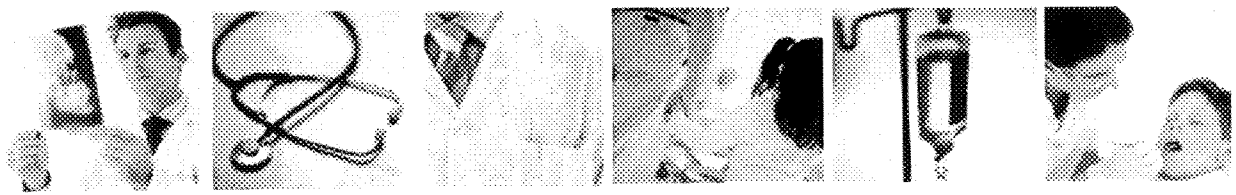
Shall include:

- the associate dean for education, or equivalent position, as a representative from each medicine, nursing, public health, or allied health service programs
- **duties** include providing advice on the development, implementation, and measurement of core competencies for patient safety to be considered for incorporation in the educational programs of the universities and colleges of this state.



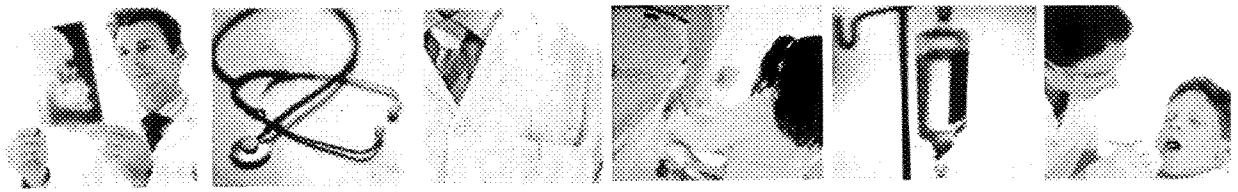
Powers and Duties of the FPSC

1. **Secure staff** necessary to properly administer the corporation.
2. **Collect, analyze, and evaluate patient safety data**, quality and patient safety indicators, medical malpractice closed claims, and adverse incidents reported to the AHCA and DOH.
3. Establish a **"near-miss"** patient safety reporting system to:
   - identify potential **systemic problems**;
   - enable publication of **system wide alerts** of potential harm;
   - develop facility-specific and statewide **options to avoid adverse incidents** and improve patient safety.
   - "near misses" to be **voluntarily** submitted by hospitals, birthing centers, and ambulatory surgical centers



Powers and Duties *con't*

4. Collaborate with appropriate state agencies in the development of **electronic health records.**
5. Provide access to health care professionals, health care facilities and the public to an active library of **evidence based medicine** and patient safety practices.
6. Develop and recommend **core competencies** in patient safety that can be incorporated into the undergraduate and graduate curricula in schools of medicine, nursing, and allied health in the state.
7. Develop and recommend programs to **educate the public** about the role of health care consumers in promoting patient safety.



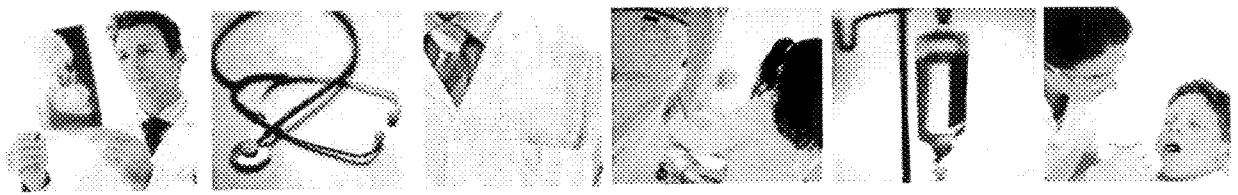
Organizing Principles

Mission Statement

- The Florida Patient Safety Corporation is dedicated to continuously improving patient safety in the state.

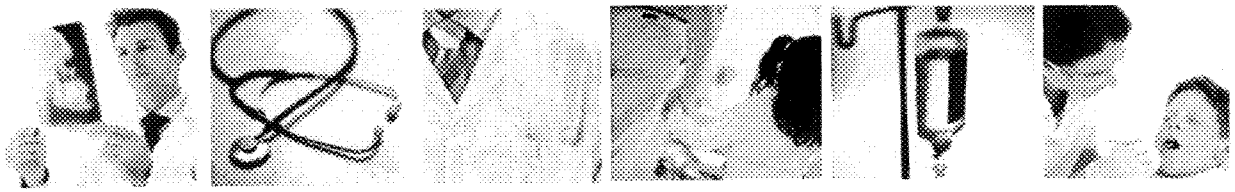
Vision Statement

- The Florida Patient Safety Corporation will be Florida's leading organization for patient safety.

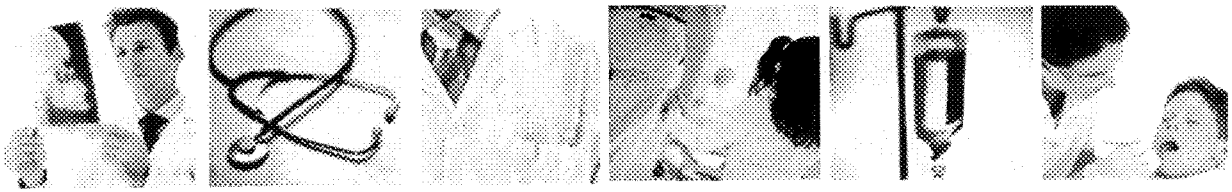


FPSC 2005-06 Goals

1. Foster and facilitate the **culture of patient safety**
2. Be the learning organization dedicated to serving health care providers and other entities through **education and information**
3. Develop **alliances and partnerships** to communicate and teach patient safety
4. Maintain **independence and sustainability** by developing financial resources and strong leadership
5. Maintain compliance with **statutory mandates**



Current
FPSC Projects:

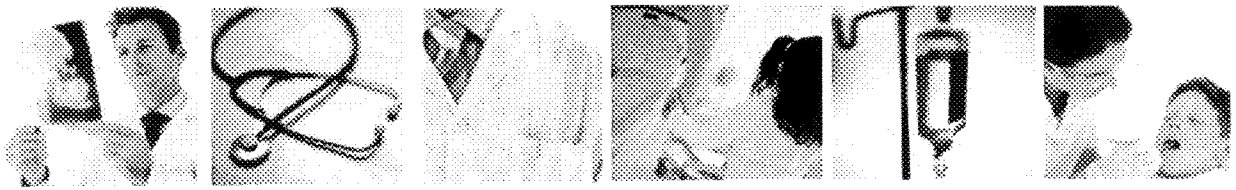


1. Creation of a Near Miss Reporting System (NMRS)

What is a *Near Miss*?

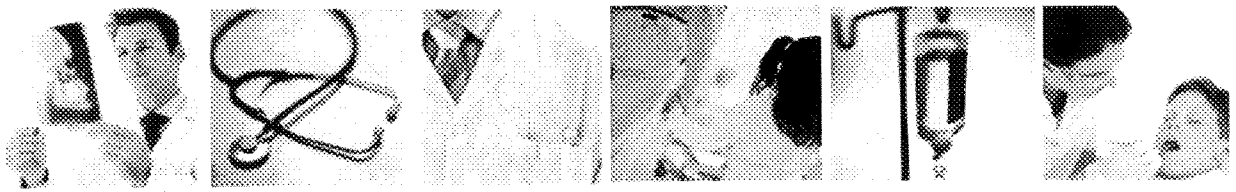
Any **potentially harmful event** that could have had an adverse result;

but, through chance or intervention, harm **was prevented**.



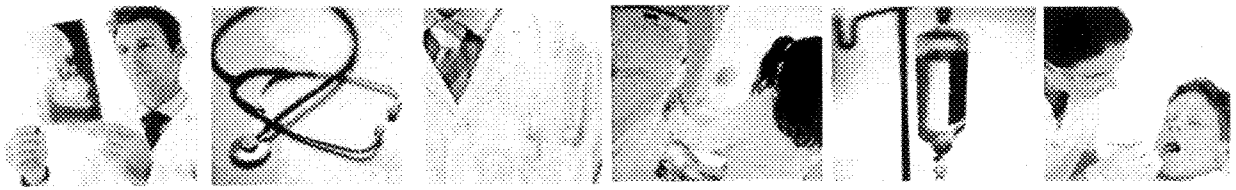
Why Look at Near Misses?

In order to ***Fix the System***,
we need to know about errors - even the one's that don't cause adverse outcomes



What Do We Want to Achieve?

We hope to create a culture in which doctors, nurses, and other healthcare providers feel comfortable enough to **voluntarily report** on near misses.



How Are We Creating the NMRS?

Through a ***partnership*** between

the Florida Patient Safety Corporation

and

The University of Miami/JMH

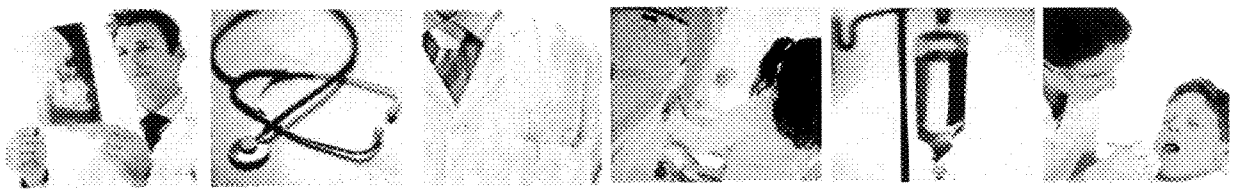
Center for Patient Safety

and

Marsh-Stars

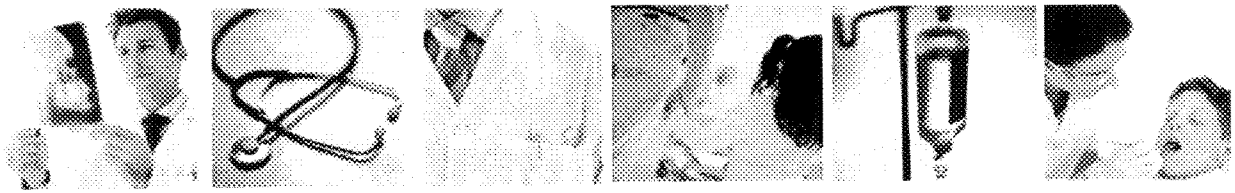
and

CRG



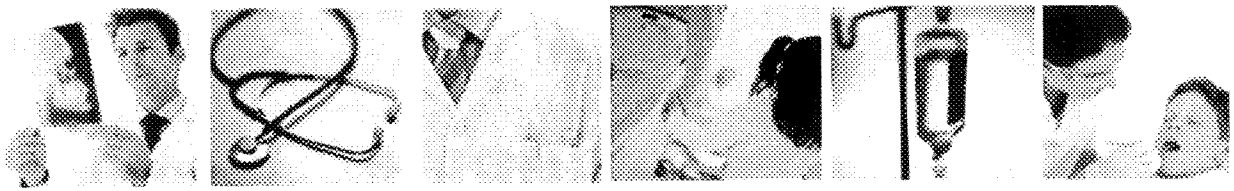
How will the NMRS Work?

- Reporting will be **voluntary, anonymous** and **independent** of mandatory reporting systems used for regulatory purposes.
- Reports of near-miss data will be **published regularly**
- **Special alerts** will be published regarding newly identified, significant risks.
- Aggregated data will be made **publicly available**.
- FPSC will report the performance and results of the near-miss project in its **annual report**.



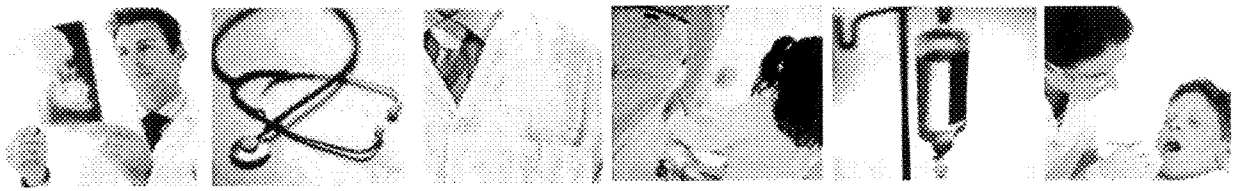
NMRS Timeline

Estimated Timeline	Task
12/2005	Identification of 24 Pilot Facilities. Includes:
	• Soliciting facilities to participate • Identification of Pilot Facilities • Identifying a near-miss coordinator at each facility • Identifying a small subset of facilities (4-6) to act as "beta testers" for program
8/2005 – 2/2006	Develop Near Miss system
1/2006 – 2/2006	Solicit feed back from beta facilities, FPSC, etc.
February 2006	Train Participating Facilities
March 2006	Go Live with NMRS



What Can We Expect From This Program?

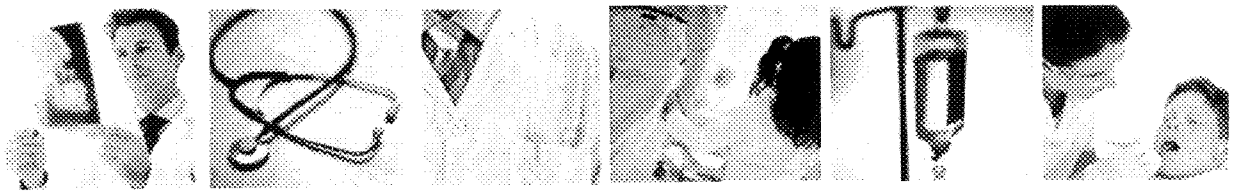
- Improved patient safety in Florida
- Decreased number of bad outcomes
- Decreased number of malpractice claims
- Education through newsletters, publications, lectures



Who Will Participate?

Volunteer Facilities:

- 20 hospitals
- 2 birthing centers
- 2 ambulatory surgical centers

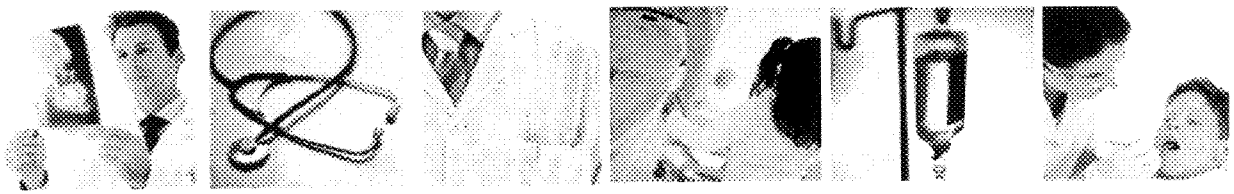


Current Projects con't:

2. Research-Based Assessments and Reports

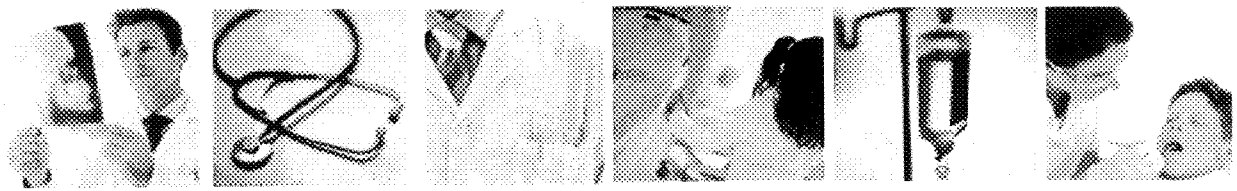
a) Code 15 System

- Study will evaluate and trend patient safety data collected from
  - adverse incident reports
  - medical malpractice closed claims
- Compare against a PSI analysis of discharge data
- Assess existing data base
- Recommend actions to prevent future adverse incidents



b) Statewide Electronic Health Information Infrastructure

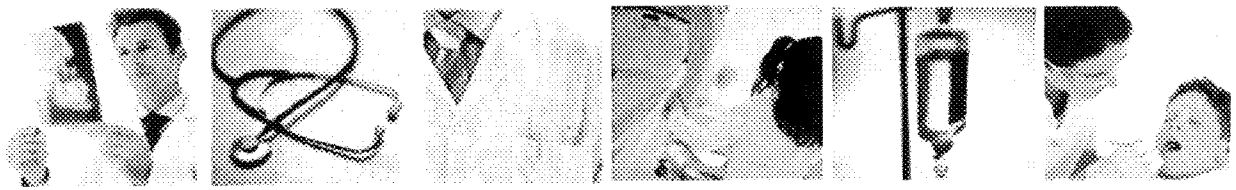
- Study will evaluate
  - Degree to which statewide electronic health information system has incorporated patient safety principles
  - Degree to which quality-related data is available and used by patients and providers
  - Degree to which accessible patient safety data assists providers and patients in making better informed decisions
- Study will be coordinated with the GHII (Governor's Health Information Infrastructure) Advisory Board and Regional Health Information Organizations (RHIOs)



c) Patient Safety Best Practices Library

- Study will assess and evaluate status of creating and maintaining a library of evidence-based, best practices relating to patient safety

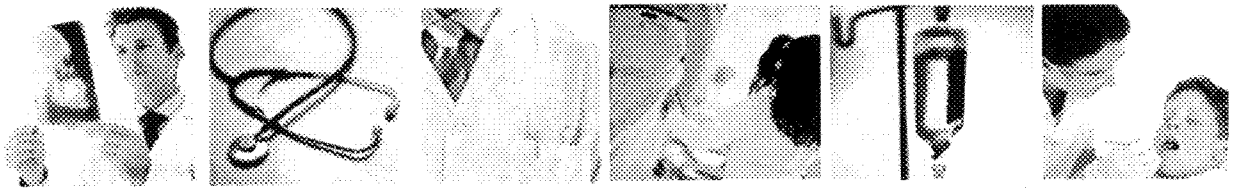
- Accessibility and relevance of such a library will be evaluated in relation to patients, providers and regulators



d) Development of Core Patient Safety Competencies for Undergraduate and Graduate Programs

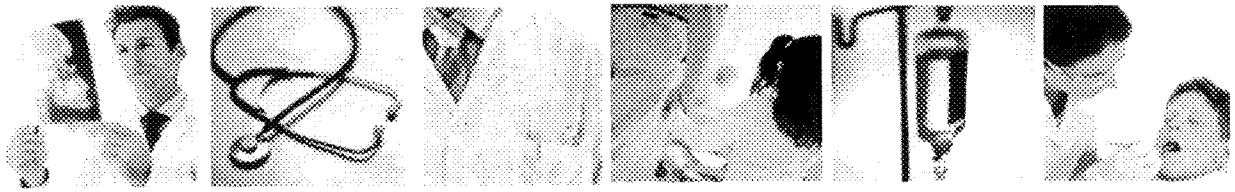
- Study will evaluate status of core competencies relevant to patient safety within the medical, nursing and allied health schools in Florida

- Plans will be developed for implementation of specific patient safety competencies into curricula of clinical educational programs



e) Patient Safety Public Education Programs

- Study will identify and evaluate success of public and private efforts to create accessible information sources for public about patient safety



f) Interagency Coordination of Patient Safety Efforts

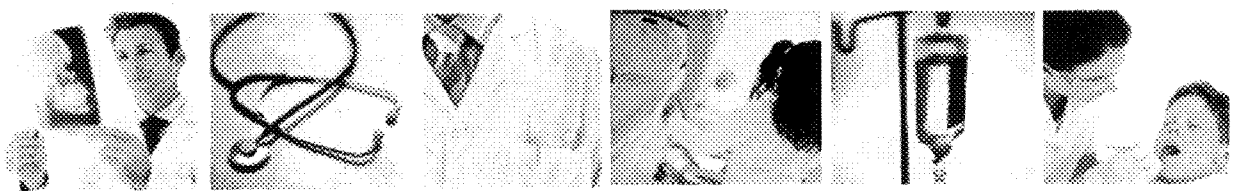
- *study will evaluate efforts to bring together myriad state agencies and programs with any patient safety responsibility – such as (but not limited to):*

➢ Office of the Attorney General

➢Boards of Medicine, Osteopathic Medicine, Nursing, Dentistry, Chiropractic, and Podiatry

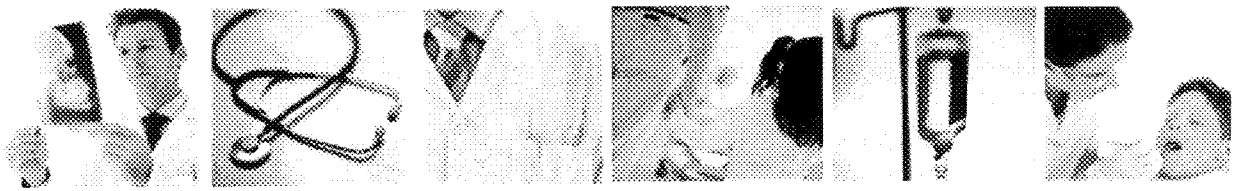
➢DOH and AHCA

➢University-based Patient Safety Centers



g) Recommendations re External Funding and Legislative Action for FPSC

- *Study will review and evaluate original legislative mandate*
- *Plan will be developed for securing external funding for research projects*
- *Legislative/regulatory actions to enhance patient safety efforts will be identified*



Who Will Perform the Studies?

the Florida Patient Safety Corporation

through a contract with

the Suncoast Center for Patient Safety

at the University of South Florida (*coordinator*)

and subcontracts with

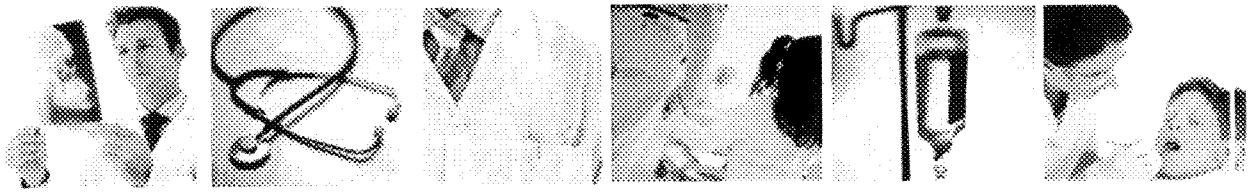
University of Florida

University of Miami

Florida State University

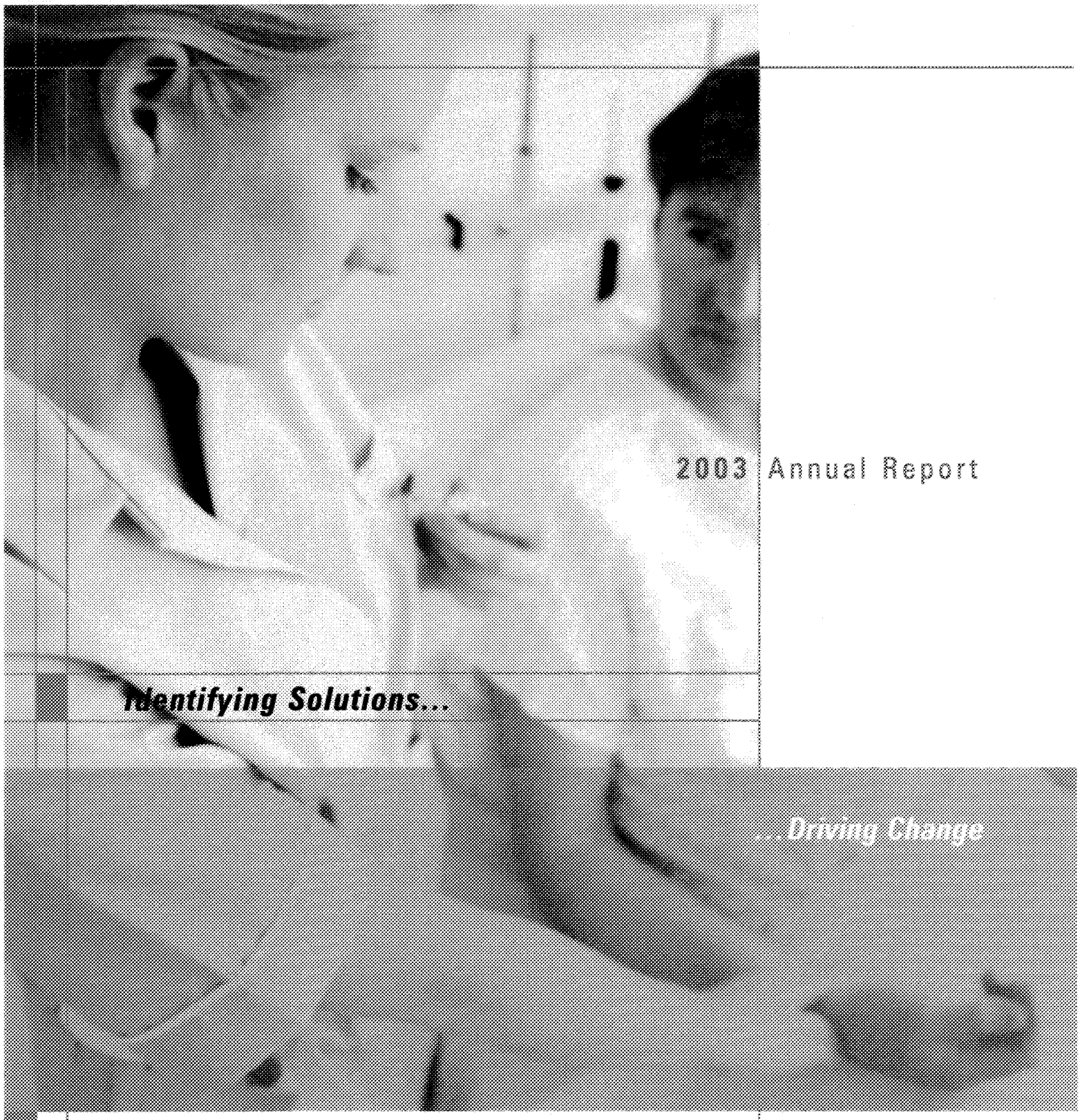
and

Nova Southeastern University



FLORIDA PATIENT SAFETY CORPORATION
OK

Background Information
National Patient Safety
Foundation

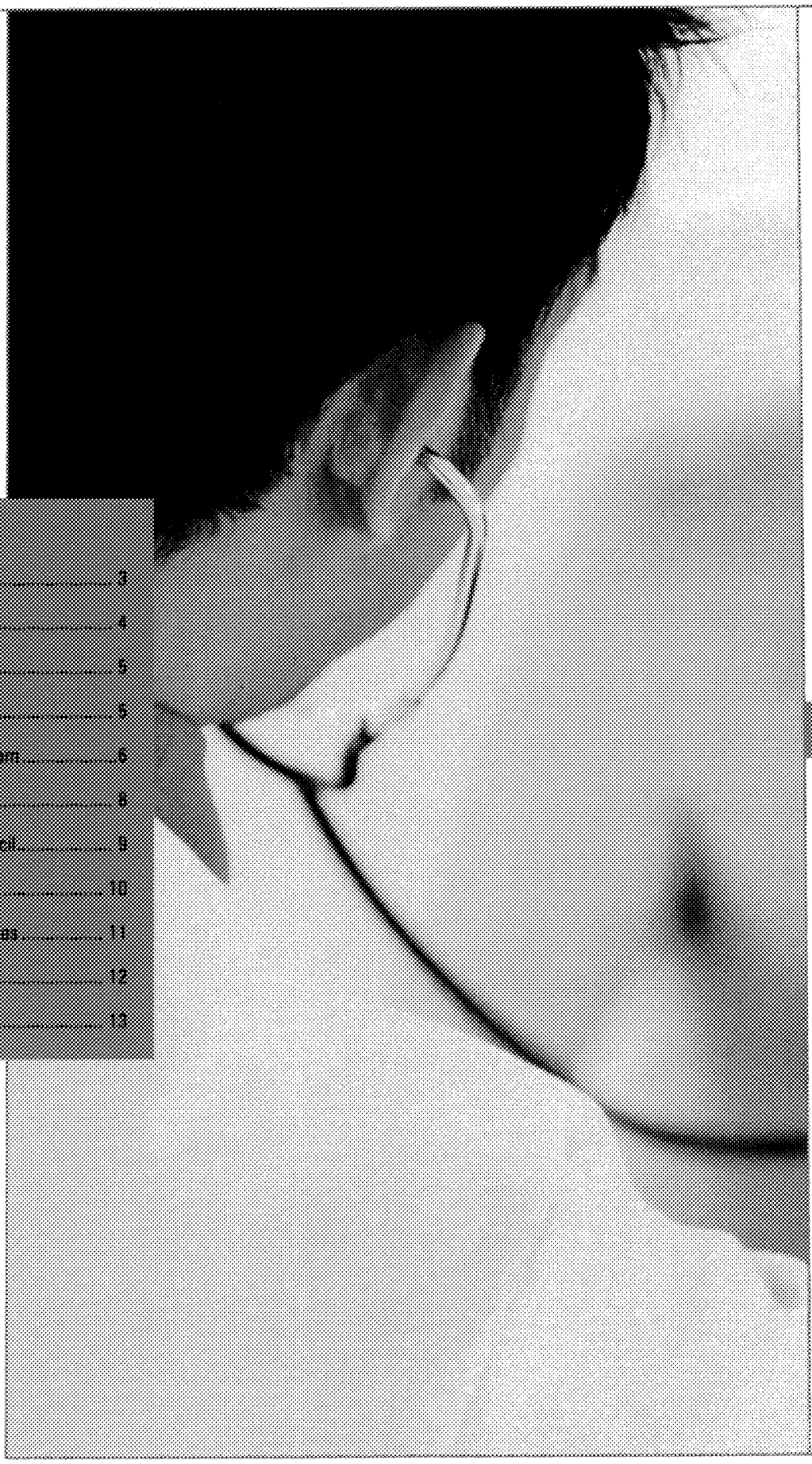


2003 Annual Report

Identifying Solutions...

...Driving Change

National Patient Safety Foundation®



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Message from the Chair

Identifying Solutions ... Driving Change

History tells us that progress is achieved in both incremental steps and giant strides. Since the inception of the National Patient Safety Foundation (NPSF) in 1996, progress in the patient safety "movement" can best be described as important but incremental, for the early focus was chiefly one of defining the scope of the challenge, which is complex and enormous.

During 2003, the NPSF made an important migration, philosophically and geographically. The philosophical migration resulted in the adoption of a strong program-driven focus on fueling tangible, measurable progress in patient safety.

Programs like hospital and health-system-based Stand-Up for Patient Safety™ and CEO-level Executive Sessions took flight and saw impressive expansion. Also in 2003, the NPSF Congress emerged as the largest international event specifically dedicated to the issue of patient safety, drawing in excess of 1,000 attendees. Delegates were enriched by more than 50 sessions and workshops delivered by our esteemed faculty. Together with a suite of other important programs, including funding original research, the NPSF is positioned from a programmatic perspective to drive progress.

The geographic migration, which moved the NPSF from Chicago to suburban Washington D.C., provided the Foundation a timely opportunity to recast our staff and operational priorities to meet these new expectations.

With these changes, the NPSF is well-positioned to serve as the focal point within the community at-large for education, research and programs that enhance patient safety. With these changes come the potential for giant strides in the patient safety movement, and the NPSF intends to be at the forefront of driving those giant strides.

Fostering changes in attitudes, cultural predispositions and institutions is difficult, even under the best of circumstances. Crossing the divide between defining the challenge of enhancing patient safety and putting into place the tools through intelligently conceived programs that drive measurable progress in making patient safety a clear and compelling priority, requires a true partnership ... within and among healthcare professionals, policymakers, researchers and academics, allied organizations, medical device manufacturers, pharmaceutical companies, and major corporations, all working in tandem with patients and their families.

The NPSF is a "big tent" organization that brings together these varied interests with a singular goal — to create a healthcare system that is driven to excel in the area of patient safety. And the NPSF has never been better positioned for success in pursuit of its critical mission.

As can be seen from the descriptions of our activities during 2003, progress was delivered in virtually every area. As important, the NPSF established in 2003 both the financial and structural momentum to carry through on its plans.

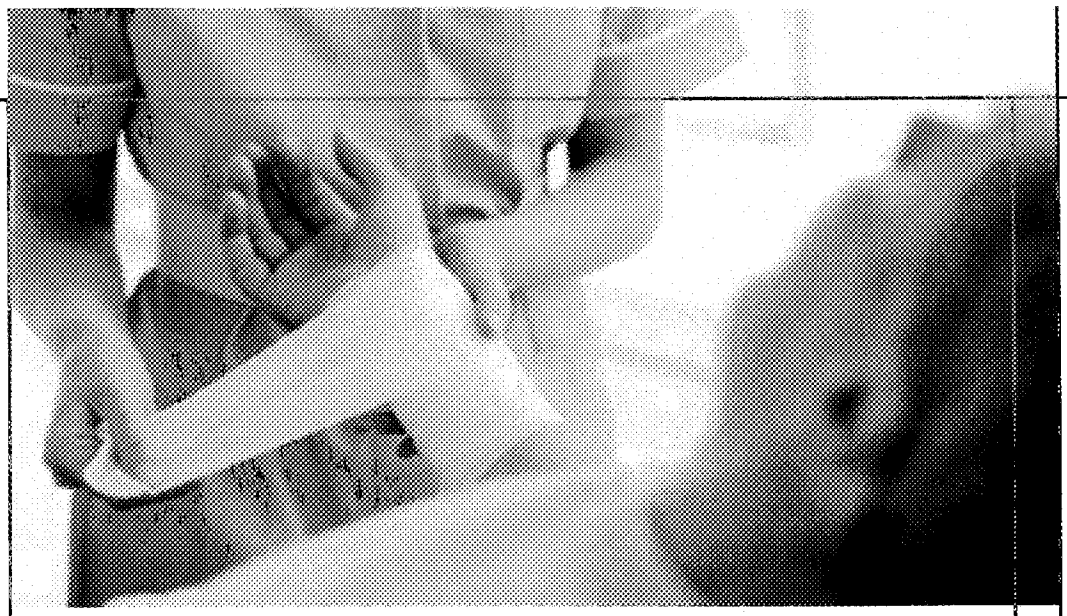
The NPSF now has in place an entrepreneurial and programmatically focused staff and infrastructure, which under the leadership of a remarkable array of volunteer leaders who serve as Board members, Distinguished Advisors and foundation supporters, will implement programs that apply a robust core body of knowledge to the singular goal of enhancing patient safety.

In large part, the NPSF arrives at this point of influence and importance because of those who preceded me in my current role as NPSF Chair. The emergence of NPSF has itself been collaboration between leaders and supporters, staff and our valued partners. None of these partnerships have been more valuable than the vision and support given to the NPSF by the American Medical Association, who provided the NPSF with the staff and infrastructure prior to our move to McLean, VA, in November 2003. For this, the NPSF is forever grateful.

In this regard, our past has been the important prologue to the excitement we feel and the momentum we see moving forward. It is an excitement born of the realization that the NPSF, through the support and dedication of its leaders, staff and supporters, is poised to make a profound difference. Together, we will prove that The Power of Partnership will deliver progress in giant strides.

Timothy A. Flaherty, MD
Past Chairman,
Board of Trustees
American Medical Association

Timothy A. Flaherty, MD
NPSF Board Chair



Our Mission: Improve the Safety of Patients

The National Patient Safety Foundation (NPSF) is a nonprofit organization dedicated solely to improving the safety of patients.

Founded in 1996 by the American Medical Association, CNA HealthPro, and 3M Company, with significant support from the Schering-Plough Corporation, NPSF is an independent organization focused on research and education, committed to making patient safety a national priority.

We accomplish this through our efforts to...

- Identify and create a core body of knowledge;
- Identify pathways to apply the knowledge;
- Develop and enhance the culture of receptivity to patient safety;
- Raise public awareness and foster communications about patient safety;
- Improve the status of the Foundation and its ability to meet its goals; and
- Serve as a central voice, and in the process, lead the transition from a culture of blame to a culture of safety.

Our Vision...

The National Patient Safety Foundation is the indispensable resource for individuals and organizations committed to improving the safety of patients.

We Believe...

- Patient safety is central to quality health care as reflected in the Hippocratic Oath: "Above All, Do No Harm."
- Prevention of patient injury, through early and appropriate response to evident and potential problems, is the key to patient safety.
- Continued improvement in patient safety is attainable only through establishing a culture of trust, honesty, integrity and open communications.
- An integrated body of scientific knowledge and the infrastructure to support its development are essential to advance patient safety significantly.
- Patient involvement in continuous learning and constant communication of information between care givers, organizations and the general public will improve patient safety.
- The system of health care is fallible and requires fundamental change to sustainably improve patient safety.

2003/2004 Board of Directors

Michael A. Alexander, MD
Chief, Division of Rehabilitation Medicine
DuPont Hospital for Children

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Director
US National Center for Patient Safety

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Intermountain Health Care Inc.

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Medical Group Management Association

Gary S. Kaplan, MD
Chairman and CEO
Virginia Mason Medical Center

Carol A. Ley, MD, MPH
Director – Occupational Medicine
3M Company

Henri R. Manasse, Jr., PhD, ScD
Executive Vice President & CEO
American Society of Health-System Pharmacists

Suzanne G. Mintz, MS
President and Co-Founder
National Family Caregivers Association

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Chief Operating Officer
Children's Hospitals and Clinics

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Senior Vice President
CNA HealthPro

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Attorney, ABC News Analyst
John Nance Productions

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American Medical Association

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President
JCAHO

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President and Chief Executive Officer
Fairview Health Services

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Vice President and Medical Director
eHealth Solutions Group, Inc.

David E. Patterson
President
The Patterson Group

Diane C. Pinakiewicz, MBA
Health Care Consultant
Interim Executive Director
National Patient Safety Foundation

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Chairman
eHealth Solutions Group, Inc.

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Vice President and Chief Medical Officer
Northwest Emergency Physicians

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Professor of Family Medicine
University of Wisconsin Medical School

Pamela A. Thompson, RN, MSN, FAAN
Chief Executive Officer
American Organization of Nurse Executives (AONE)

Lawrence W. Way, MD
Professor and Vice Chair, Department of Surgery
Director of Videoscopic Surgery
University of California at San Francisco Medical Center

Josie R. Williams, MD, MMM, CPE
Executive Director of the Program for Patient Safety
The Texas A&M University System Health Science Center

Janet Woodcock, MD
Director
Center for Drug Evaluation & Research
Food & Drug Administration

Distinguished Advisors

The NPSF Distinguished Advisors are a prestigious group of the patient safety industry's most accomplished leaders. Together they advise and assist the NPSF on issues of content and strategic direction. Distinguished Advisors are appointed at the recommendation and approval of the NPSF Board of Directors.

Donald M. Berwick, MD, MPP
President and CEO
Institute for Healthcare Improvement

Carolyn M. Clancy, MD
Director
Agency for Healthcare Research and Quality

James B. Conway, MBA, MSC, CHE
Executive Vice President & Chief Operating Officer
Dana Farber Cancer Institute

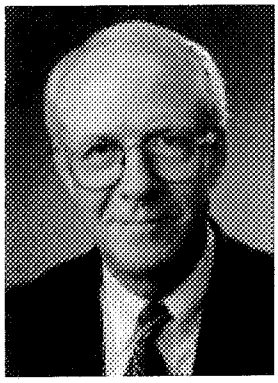
Kenneth W. Kizer, MD, MPH
President and CEO
The National Quality Forum

David Lawrence, MD
Retired Chairman & CEO
Kaiser Foundation Health Plan and Hospitals

Lucian L. Leape, MD
Adjunct Professor of Health Policy
Harvard School of Public Health

Stand-Up for Patient Safety Program

The National Patient Safety Foundation founded the Stand-Up for Patient Safety program in 2002 to provide a meaningful way for hospitals and health systems to participate in the patient safety movement and demonstrate their commitment to this important issue. The Stand-Up program provides practical tools to enhance existing patient safety and quality improvement initiatives. It also offers educational programs, information resources, topical meetings, and online forums for sharing patient safety innovations and best practices. These benefits are designed for use by specific audiences at member institutions – administration, trustees, clinical staff, patients and families, and public relations and marketing personnel.



NPSF Board Member David R. Page, MHA Chair, Stand-Up for Patient Safety; President and Chief Executive Officer Fairview Health Services

To ensure member driven benefits, the NPSF takes Stand-Up program direction from member hospitals and health systems. Benefits are based on members' patient safety educational needs, the topics they wish to address, the resources they require, and the constituent groups they need to educate, such as board members, physicians, nurses, patients and their families.

The Stand-Up Program offers conferences on safety topics, forums for sharing best practices, educational video tapes, and a comprehensive set of resources, as well as materials for internal and external communications.

Charter and Partner memberships in the Stand-Up campaign are available to interested hospitals and health systems. For more information contact Margaret Hogan at 703-506-3280 or via e-mail at mhogan@npsf.org.

Founding Members

Ascension Health
St. Louis, MO

Baptist Health South Florida
Coral Gables, FL

Children's Hospitals & Clinics
Minneapolis, MN

Exempla Healthcare
Denver, CO

Fairview Health Services
Minneapolis, MN

Martin Memorial Health Systems
Stuart, FL

Memorial Hermann Healthcare System
Houston, TX

Mission St. Joseph's Health System
Asheville, NC

North Shore-Long Island Jewish Health System
Great Neck, NY

Partners HealthCare, Massachusetts General Hospital/Brigham & Women's Hospital
Boston, MA

Scott & White
Temple, TX

Sisters of St. Francis Health Services, Inc.
Mishawaka, IN

St. Joseph Regional Health Center
Bryan, TX

St. Vincent Hospital and Health Services
Indianapolis, IN

Trinity Health
Novi, MI

Vanderbilt University Medical Center
Nashville, TN

Virginia Mason Medical Center
Seattle, WA

Founding Funders

Medical Liability Mutual Insurance Co.
New York, NY

NORCAL Mutual Insurance Company
San Francisco, CA

Physicians Insurance Company of Wisconsin
Madison, WI

Members

Akron General Medical Center
Akron, OH

Alvarado Hospital Medical Center
San Diego, CA

Arnot Ogden Medical Center
Elmira, NY

Atlanta Medical Center
Atlanta, GA

Aurora Health Care
Milwaukee, WI

Bellevue Hospital
Bellevue, OH

Brookwood Medical Center
Birmingham, AL

Brotman Medical Center
Culver City, CA

Brownsville Medical Center
Brownsville, TX

Centinela Hospital Medical Center
Inglewood, CA

Central Carolina Hospital
Sanford, NC

Century City Hospital
Los Angeles, CA

Chapman Medical Center
Orange, CA

Children's Hospital of Wisconsin
Milwaukee, WI

Christus Saint Michael Health
Texarkana, TX

Coastal Communities Hospital
Santa Anna, CA

Columbia Hospital
Milwaukee, WI

Community and Mission Hospital of Huntington Park
Huntington Park, CA

Community Hospital of Los Gatos
Los Gatos, CA

Continuum Health Partners, Inc.
New York, NY

Coral Gables Hospital
Coral Gables, FL

Creighton University Medical Center
Omaha, NE

Cypress Fairbanks Medical Center
Houston, TX

Daniel Freeman Marina Hospital
Marina Del Ray, CA

Daniel Freeman Memorial Hospital
Inglewood, CA

Dartmouth-Hitchcock Medical Center
Lebanon, NH

Delray Medical Center
Delray Beach, FL

Des Peres Hospital
St. Louis, MO

Desert Regional Medical Center
Palm Springs, CA

Doctors Hospital of Dallas
Dallas, TX

Doctors Hospital of Jefferson
Metairie, LA

Doctors Hospital of Manteca
Manteca, CA

Doctors Medical Center - San Pablo
San Pablo, CA

Doctors Medical Center of Modesto
Modesto, CA

East Cooper Regional Medical Center
Mt. Pleasant, SC

Ellis Hospital
Schenectady, NY

Encino-Tarzana Regional Medical Center - Encino
Encino, CA

Encino-Tarzana Regional Medical Center - Tarzana
Tarzana, CA

Evanston Northwestern Healthcare
Evanston, IL

Florida Medical Center
Ft. Lauderdale, FL

Forest Park Hospital
St. Louis, MO

Fountain Valley Regional Hospital and Medical Center
Fountain Valley, CA

Froedtert and Community Health
Milwaukee, WI

Frye Regional Medical Center
Hickory, NC

Garden Grove Hospital and Medical Center
Garden Grove, CA

Garfield Medical Center
Monterey Park, CA

Good Samaritan Hospital
Dayton, Ohio

Good Samaritan Medical Center
West Palm Beach, FL

Graduate Hospital
Philadelphia, PA

Greater El Monte Community Hospital
El Monte, CA

Gulf Coast Medical Center
Biloxi, MS

Hackensack University Medical Center
Hackensack, NJ

Hahnemann University Hospital
Philadelphia, PA

Hancock Memorial Hospital and Health Services
Greenfield, IN

Henry Ford Health System
Detroit, MI

Hialeah Hospital
Hialeah, FL

Hilton Head Medical Center and Clinics
Hilton Head, SC

Hollywood Medical Center
Hollywood, FL

Hollywood Presbyterian Medical Center
Los Angeles, CA

Houston Northwest Medical Center
Houston, TX

Iowa Health System
Des Moines, IA

Irvine Regional Hospital and Medical Center
Irvine, CA

John F. Kennedy Memorial Hospital
Indio, CA

Katherine Shaw Bethea Hospital
Dixon, IL

Kenner Regional Medical Center
Kenner, LA

Lake Meade Hospital Medical Center
North Las Vegas, NV

Lake Pointe Medical Center
Rowlett, TX

Lakewood Regional Medical Center
Lakewood, CA

Los Alamitos Medical Center
Los Alamitos, CA

Major Hospital
Shelbyville, IN

Meadowcrest Hospital
Gretna, LA

Medical College of Pennsylvania Hospital
Philadelphia, PA

Memorial Healthcare System
Hollywood, FL

Memorial Medical Center - Baptist
New Orleans, LA

Memorial Medical Center
Springfield, IL

Memorial Medical Center - Mercy
New Orleans, LA

Methodist Hospital
Houston, TX

Methodist Le Bonheur Healthcare
Memphis, TN

MetroWest Medical Center
Framingham, MA

Miami Valley Hospital
Dayton, Ohio

Midland Memorial Hospital
Midland, TX

Midway Hospital Medical Center
Los Angeles, CA

Monterey Park Hospital
Monterey Park, CA

Nacogdoches Medical Center
Nacogdoches, TX

New York-Presbyterian Hospital and Health System
New York, NY

North Fulton Regional Hospital
Roswell, GA

North Ridge Medical Center
Fort Lauderdale, FL

North Shore Medical Center
Miami, FL

North Shore Regional Medical Center
Slidell, LA

Olmsted Medical Center
Rochester, MN

Palm Beach Gardens Medical Center
Palm Beach Gardens, FL

Palmetto General Hospital
Hialeah, FL

Park Plaza Hospital
Houston, TX

Parkway Regional Medical Center
N. Miami Beach, FL

Parrish Medical Center
Titusville, FL

Piedmont Healthcare System
Rock Hill, SC

Pinecrest Rehabilitation Center
Delray Beach, FL

Placentia Linda Hospital
Placentia, CA

Plaza Specialty Hospital
Houston, TX

Providence Memorial Hospital
El Paso, TX

Redding Medical Center
Redding, CA

RHD Memorial Medical Center
Dallas, TX

Rio Vista Physical Rehabilitation Hospital
El Paso, TX

Robert Wood Johnson University Hospital at Hamilton
Hamilton, NJ

Rockcastle Hospital, Inc.
Mt. Vernon, KY

Roseau Area Hospital
Roseau, MN

Roxborough Memorial Hospital
Philadelphia, PA

Saint Francis Hospital
Memphis, TN

Saint Francis Butler Hospital
Bartlett, TN

Saint Louis University Hospital
St. Louis, MO

Saint Vincent's Hospital
Worcester, MA

San Dimas Community Hospital
San Dimas, CA

San Jacinto Methodist Hospital
Baytown, TX

San Ramon Regional Center
San Ramon, CA

Shelby Regional Medical Center
Center, TX

Sierra Medical Center
El Paso, TX

Sierra Vista Regional Medical Center
San Luis Obispo, CA

South Fulton Medical Center
East Point, GA

Spalding Regional Medical Center
Griffin, GA

St. Alexius Hospital
St. Louis, MO

St. Charles General Hospital
New Orleans, LA

St. Christopher's Hospital for Children
Philadelphia, PA

St. Cloud Hospital
St. Cloud, MN

St. Joseph's Community Hospital
West Bend, WI

St. Mary's Medical Center
W. Palm Beach, FL

St. Rita's Medical Center
Lima, OH

Stony Brook University Hospital
Stony Brook, NY

Suburban Medical Center
Paramount, CA

Surgery Center of Nacogdoches
Nacogdoches, TX

Sylvan Grove Hospital
Jackson, GA

Trinity Medical Center
Carrolton, TX

Twin Cities Community Hospital
Templeton, CA

University of Pennsylvania Health System
Philadelphia, PA

University of Texas MD Anderson Cancer Center
Houston, TX

USC University Hospital
Los Angeles, CA

VA Medical Center
Butler, PA

Warminster Hospital
Warminster, PA

West Boca Medical Center
Boca Raton, FL

Western Medical Center - Anaheim
Anaheim, CA

Western Medical Center - Santa Ana
Santa Ana, CA

White River Health System, Inc.
Batesville, AR

Whittier Hospital Medical Center
Whittier, CA

Winthrop University Hospital
New York, NY

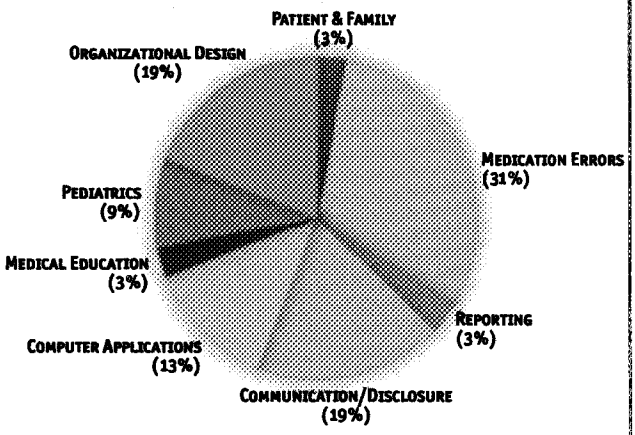
Research

The Research Initiative

In 2003, NPSF collaborated again with the American Medical Association (AMA) and The Patrick and Catherine Weldon Donaghue Medical Research Foundation to award $200,000 to support two research projects seeking to address important patient safety issues.

Since the NPSF Research program began in 1998, NPSF has received over 600 investigator-driven proposals for innovative patient safety research projects. The most commonly proposed topics since 2001 range from an array of medication errors projects to population-specific projects for elderly or pediatric patients.

To date, the NPSF has supported 21 research projects through $2 million in grant funding. Over two-thirds of these grants have been awarded to interdisciplinary teams to support research on medication errors, organizational design, and communication or disclosure issues.



NPSF funded projects by category

"The NPSF support was extremely influential in allowing me to study diagnostic errors in some detail and to meet key people from around the world with a mutual interest in this area. Thanks!"

Mark Graber, MD, FACP
NPSF Grant Principal Investigator
Chief, Medical Service
Northport VAMC

2003 Research Awards

Improving the Safety and Efficacy of Pediatric Sedation Practice Through the Creation of the Pediatric Sedation Research Consortium

The 2003 James S. Todd Memorial Award, co-sponsored by the American Medical Association, was awarded to a team from the Dartmouth-Hitchcock Medical Center. Members of this team include: Joseph P. Cravero, MD, FAAP, Michael L. Beach, MD, PhD, Kristen Chambers, MS, and Susan M. Gallager.

Their study will create a web-based database that will allow them to explore pediatric sedation and determine what techniques and providers have the highest success rates and the best safety profiles.

NPSF expects this research will guide the development of future safe pediatric sedation systems. This project should also serve as a model for the development of safe systems of care for children in other areas of medicine where current practice is highly non-standardized or has been under-examined.

Can Knowledge from a Clinical Decision Support System Developed at an Academic Medical Center Be Applied to Other Hospitals and Populations Throughout an Integrated Delivery Network?

NPSF, in conjunction with The Donaghue Foundation, is sponsoring the work of a Yale New Haven Health System team. Investigators include: Martha J. Radford, MD, Dianne Collins, RN, Lisa Stump, RPh, Richard Shiffman, MD, MCIS, Jennifer Travers, Catherine O'Neill, and Wei Teng, PhD.

This pilot project will determine whether it is technically feasible to disseminate throughout a network knowledge gained from a single institution's clinical decision support across an integrated delivery network. In the long term, demonstrating applicability to disparate institutions and identifying factors that facilitate change would eliminate the need to reproduce the knowledge locally and dramatically facilitate the implementation of effective medication safety programs that include protection for both the pediatric and adult populations.

Patient and Family Advisory Council

The Patient and Family Advisory Council (PFAC) was initiated by the NPSF to ensure that the perspectives of patients and families, particularly those who have experienced harm in the delivery of healthcare services, are incorporated into the programs, policies, and strategic direction of NPSF through advice and input to the Board of Directors and staff.

PFAC Vision Statement...

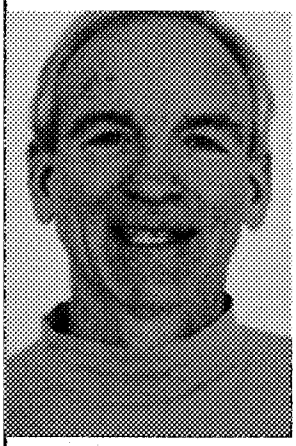
To ensure that the NPSF works in partnership with patients and families in achieving its mission and that their perspectives are heard and considered in the NPSF's policy initiatives, strategic direction, and program activities.

The NPSF PFAC supports a proactive, preventive approach to error reduction. PFAC seeks to work in partnership with healthcare providers to reduce error in the delivery of healthcare services and to collaborate with other groups working on patient safety.

PFAC seeks to maintain both a national and a local perspective, serving as a bi-directional communication vehicle, informing the NPSF of regional needs and desires and informing local coalitions of NPSF and other national activities.

PFAC seeks to represent those who have direct experience with healthcare error; we recognize, respect, and value the varied backgrounds and beliefs of our individual members.

In January 2003, PFAC created its **National Agenda for Action: Patients and Families in Patient Safety — Nothing About Me, Without Me** for healthcare organizations — at all levels — to involve patients and families in systems and patients' safety problems. Four areas of involvement include: education and raising awareness, building the culture, suggested areas of research, and developing support services to mitigate the effects of a harmful error.



Donald W. Parsons, MD
Co-Chair, PFAC;
Vice President and
Medical Director,
eHealth Solutions
Group, Inc.

Current PFAC Members

Ilene Corina,* Co-Chair
Co-President
PULSE of America

Donald W. Parsons,* MD,
Co-Chair
Vice President and
Medical Director
eHealth Solutions Group, Inc.

Jennifer Dingman
Founder
PULSE of Colorado

Susan Edgman-Levitan,* PA
Executive Director
John D. Stoeckle Center for
Primary Care

Mary Foley,* MS, RN
Immediate Past President
American Nurses Association

Dan Ford, MBA

Roxanne Goeltz

Linda Golodner*
President
National Consumers League

Doni Haas,* RN
Licensed Healthcare Risk
Manager

Tim Kolb

Deborah Malone, RN
President
PULSE of Colorado

Becky Martins

Rebecca McCabe

Suzanne G. Mintz,* MS
President and Co-Founder
National Family Caregivers
Association

Patti Heart O'Regan, ARNP

Matthew M. Rice,*
MD, JD, FACEP
Vice President and Chief
Medical Officer
Northwest Emergency
Physicians

Arlene Salamendra

Pamela Thompson,*
MSN, RN, FAAN
Chief Executive Officer
American Organization of
Nurse Executives

*NPSF Board Member

Patient Safety Awareness Week

Patient Safety Awareness Week was held March 9–15, 2003. The theme was "Communication and Partnership: Safety starts with all of us."

Led by the NPSF, Patient Safety Awareness Week is a national education and awareness-building campaign for improving patient safety at the local level.

Patient Safety Awareness Week provided resources via the NPSF Web site and special programs for its Stand-Up members. In 2003, it was celebrated in all 50 states and Washington, DC, as well as England, Denmark, Canada, Japan, Puerto Rico, Italy, and China.

The Executive Sessions

The NPSF Executive Sessions on Patient Safety are based on a model developed by Harvard's Kennedy School of Government to allow practitioners and academics to search together for plausibly effective answers to important public problems. This program, which is a regional application of the model, is comprised of a high-level, confidential working group of healthcare executives who meet biannually over two years to improve the safety of patients in their community or region. The leaders involved include Chief Executive Officers, Board Chairs, QIOs, Payers, Hospital Association members, Universities, and other important leaders from the healthcare community. The program has two main objectives:

- To create an environment for healthcare executives to learn from each other about how to create safe health care in their organizations and in the community.
- To support and catalyze leaders' efforts to effectively motivate and mobilize patient safety improvements in the healthcare delivery system.

Minnesota Executive Session

The first regional Executive Session on Patient Safety was launched in 2001 in St. Paul, Minnesota. The Minnesota Executive Session has been extremely successful in creating threshold change in patient safety, including facilitating the introduction and passage of a model medical error reporting bill in the state legislature. Approximately 30 stakeholders from healthcare institutions in Minneapolis and St. Paul and representatives from the Mayo Clinic in Rochester participate in this ongoing initiative.

The Minnesota Session has focused on five areas:

- Surveying their organizations and sharing the results of best practice inventories and leadership practices;
- Analyzing the cost of adverse events and patient safety improvements;
- Developing mandatory adverse event legislation;
- Advising and collaborating with the university to create a comprehensive health professional education initiative; and
- Providing oversight of and facilitating the work of a citywide initiative to implement best practices.

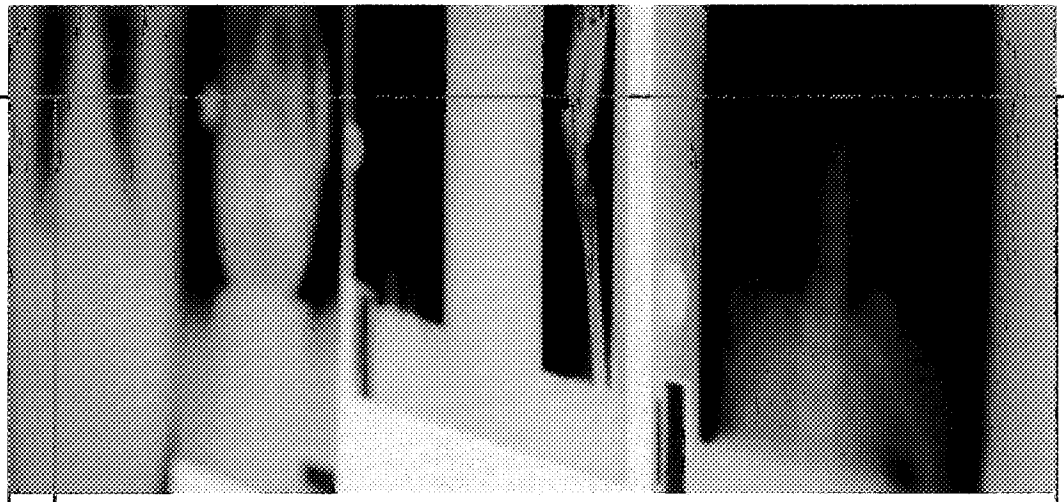
NPSF Board Member
Carol L. Ley, MD, MPH
Chair, Executive Sessions;
Director,
Occupational Medicine
3M Company

As a result of these tremendous advances, Minnesota made an unprecedented decision to continue to hold Executive Sessions past the traditional two years. In 2003, through partial corporate funding and funding raised by each participating hospital, they have continued to meet and advance patient safety initiatives in their community.

Indianapolis Executive Session

NPSF launched its second regional Executive Session in Indianapolis in November of 2003. The Indianapolis Executive Session on Patient Safety represents a firm commitment to create change across the entire community. In addition, the group has focused on creating an Indianapolis Patient Safety Coalition that has acted as the action arm of the Executive Session.

A number of resources support this project, including contributions from corporations and foundations. The planning group included representatives from NPSF and various corporations, foundations, hospitals, and health systems.



Corporate Councils and Roundtables Program

National Patient Safety Foundation announced in 2003 that six leading healthcare products and services companies joined its Corporate Councils and Roundtables (CCR) program to develop innovative, attainable, and practical patient safety solutions. The CCR program provides a forum for these industry leaders to work alongside NPSF Board members, healthcare providers, and hospital executives to reduce medical errors. The inaugural Corporate Council includes 3M Company, ALARIS Medical Systems, Inc., Battelle, Cardinal Health, Inc., Philips, and Precision Dynamics Corporation.

The CCR program provides unique opportunities for participating companies to enhance their patient safety initiatives by providing educational tools through which to engage their clients more successfully. These tools encourage the members to tailor their product descriptions and reports to the hospital CEO in a concise and patient-centered manner; allowing the member to present their product solutions by differentiating themselves on performance impact. Among the Council's goals are the provision of clear, standardized value proposition communication frameworks that are patient-centered, evidence based, and systems-performance focused; which can be systematically applied to communicating patient impact through the NPSF in order to accelerate adoption of high impact products and services.

In addition, CCR members may access the NPSF Speakers Bureau, leveraging the expertise of the NPSF Board. Council members may also participate in the Speakers Bureau, providing patient safety knowledge specific to their industry, encouraging dialogue with the Board, the Congress and Stand-Up members. Finally, the NPSF Board will turn to its CCR members for guidance and advice on emerging patient safety topics and technology. By pooling their resources and expertise, the NPSF Board and Corporate Council members can engage in joint problem-solving and collaborative opportunities that will advance the cause and culture of patient safety.

2003 Congress – "Let's Get Results: Improving the Safety of Patients"

The NPSF Annual Congress is the largest convener in the world of an event solely dedicated to enhancing patient safety. Each program is designed to provide participants an interactive opportunity to learn about the latest in patient safety from the nation's most notable experts with a particular focus on enhancing patient safety in the clinical environment.

6th Annual NPSF Patient Safety Congress
Let's Get On With It!
Improving the safety of patients

In 2003, "Let's Get Results: Improving the Safety of Patients" gathered over a thousand of the nation's healthcare leaders including hospital CEOs, CFOs, risk managers, physicians, nurses, healthcare administrators, equipment manufacturers and patient safety advocates in Washington, D.C.

Secretary of Health and Human Services, Tommy Thompson, opened the Congress by announcing two new Food and Drug Administration (FDA) proposals aimed at improving patient safety. The proposed rules would require bar coding on medications and would improve reporting requirements for safety problems involving medicines.

Other speakers included experts from the country's leading hospitals and health systems, as well as such organizations as the American Nurses Association, American Society for Healthcare Risk Management, Colorado Patient Safety Coalition, Institute for Safe Medication Practices, Leapfrog Group, Massachusetts Coalition for the Prevention of Medical Errors, National Quality Forum, Niagara Health Quality Coalition, PULSE of Colorado, and the Foundation for Healthy Communities.

NPSF Board Member Susan Edgman-Levitan, PA Congress Co-Chair; Executive Director John D. Stoeckle Center for Primary Care

Endorsing Organizations included the following:

AARP
Agency for Healthcare Research and Quality (AHRQ)
American Association for the Advancement of Science (AAAS)
American Hospital Association (AHA)
American Medical Association (AMA)
American Nurses Association (ANA)
American Organization of Nurse Executives (AONE)
American Society for Healthcare Risk Management
American Society for Quality (ASQ)
American Society of Health-System Pharmacists (ASHP)
Anesthesia Patient Safety Foundation
Annenberg Center for Health Sciences (at Eisenhower Medical Center)
Association for the Accreditation of Human Research Protection Programs
Association of periOperative Registered Nurses (AORN)
Bridge Medical, Inc.
Council on Public Interest Anesthesia
Department of Defense
FDA Center for Drug Evaluation and Research
Federation of American Hospitals
Institute for Healthcare Improvement (IHI)
Institute for Safe Medication Practices (ISMP)
Joint Commission Resources
Medical College of Wisconsin
Medical Group Management Association (MGMA)
National Association for Healthcare Quality
National Committee on Quality Assurance
National Consumers League
National Health Council
National Patient Safety Foundation
Patient Safety Officers Society (PSOS)
PhRMA
Physician Insurers Association of America
Premier, Inc.
USP Center for the Advancement of Patient Safety
Veterans Health Administration National Center for Patient Safety
VHA Inc.

Background Information
Institute for Healthcare Improvement

Annual Report

Listing of FL Hospitals Participating in the IHI 100,000 Lives Campaign

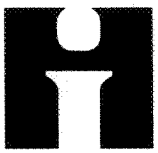
Florida Hospitals Fully Committed to the 100000 Lives Campaign
12/07/05

All Children's Hospital -- St. Petersburg, FL -- F00272
Aventura Hospital and Medical Center -- Aventura, FL -- F01101
Baptist Health -- Jacksonville, FL -- F02670
Baptist Hospital of Miami -- Miami, FL -- F02045
Baptist Hospital, Inc. -- Pensacola, FL -- F00242
Bay Medical Center -- Panama City, FL -- F00903
Bethesda Memorial Hospital -- Boynton Beach, FL -- F01785
Blake Medical Center -- Bradenton, FL -- F01532
Boca Raton Community Hospital -- Boca Raton, FL -- F00628
Brandon Regional Hospital -- Brandon, FL -- F01338
Broward General Medical Center -- Fort Lauderdale, FL -- F01409
Cape Canaveral Hospital -- Cocoa Beach, FL -- F00510
Cape Coral Hospital -- Cape Coral, FL -- F02040
Capital Regional Medical Center -- Tallahassee, FL -- F01575
Cedars Medical Center -- Miami, FL -- F01820
Central Florida Regional Hospital -- Sanford, FL -- F01334
Charlotte Regional Medical Center -- Punta Gorda, FL -- F02609
Citrus Memorial Hospital -- Inverness, FL -- F00353
Cleveland Clinic Florida Hospital Naples -- Naples, FL -- F01551
Cleveland Clinic Hospital -- Weston, FL -- F01262
Columbia Hospital -- Palm Beach, FL -- F01950
Community Hospital -- New Port Richey, FL -- F01428
Coral Gables Hospital -- Coral Gables, FL -- F01266
Coral Springs Mecial Center -- Coral Springs, FL -- F02501
Delray Medical Center -- Delray Beach, FL -- F01269
Doctors Hospital of Sarasota -- Sarasota, FL -- F01481
Doctors Hospital -- Coral Gables, FL -- F01802
East Pasco Medical Center -- Zephyrhills, FL -- F02163
Edward White Hospital -- St. Petersburg, FL -- F01342
Englewood Community Hospital -- Englewood, FL -- F01819
Fawcett Memorial Hospital -- Port Charlotte, FL -- F01112
Flagler Hospital -- St. Augustine, FL -- F00008
Florida Hospital - Fish Memorial -- Orange City, FL -- F02166
Florida Hospital - Flagler -- Palm Coast, FL -- F02167
Florida Hospital - Lake Placid -- Lake Placid, FL -- F02168
Florida Hospital - Ormond Memorial -- Ormond Beach, FL -- F02169
Florida Hospital - Waterman -- Tavares, FL -- F02170
Florida Hospital - Wauchula -- Wauchula, FL -- F02171
Florida Hospital Deland -- DeLand, FL -- F02162
Florida Hospital Heartland Medical Center -- Sebring, FL -- F02172
Florida Hospital -- Orlando, FL -- F02165
Florida Medical Center -- Fort Lauderdale, FL -- F01278
Fort Walton Beach Medical Center -- Fort Walton Beach, FL -- F01948

Good Samaritan Medical Center -- West Palm Beach, FL -- F01282
Gulf Coast Hospital -- Fort Myers, FL -- F01635
Halifax Community Health -- Daytona Beach, FL -- F02058
Halifax Medical Center -- Daytona Beach, FL -- F01814
Health Central -- Ocoee, FL -- F00870
Health Park Medical Center Hospital -- Fort Myers, FL -- F02041
Heart of Florida Regional Medical Center -- Davenport, FL -- F02538
Helen Ellis Memorial Hospital -- Tarpon Springs, FL -- F01438
Hernando HealthCare Inc -- Brooksville, FL -- F02606
Hialeah Hospital -- Hialeah, FL -- F01286
Highlands Regional MC -- Sebring, FL -- F02529
Hollywood Medical Center -- Hollywood, FL -- F01288
Holmes Regional Medical Center -- Melbourne, FL -- F00509
Holy Cross Hospital -- Fort Lauderdale, FL -- F01130
Homestead Hospital -- Homestead, FL -- F01082
Imperial Point Medical Center -- Ft. Lauterdale, FL -- F02548
Jackson Health System -- Miami, FL -- F01868
James A. Haley VA Hospital -- Tampa, FL -- F02739
JFK Medical Center -- Atlantis, FL -- F01431
Kendall Regional Medical Center -- Miami , FL -- F01542
Lake City Medical Center -- Lake City, FL -- F01629
Lakeland Regional Medical Center -- Lakeland, FL -- F02056
Largo Medical Center -- Largo, FL -- F01422
Lawnwood Regional Medical Center and Heart Institute -- Fort Pierce, FL -- F01448
Lee Memorial Hospital -- Fort Myers, FL -- F02039
Leesburg Regional Medical Center -- Leesburg, FL -- F00811
Lower Keys Medical Center -- Key West, FL -- F02535
Mariners Hospital -- Tavernier, FL -- F02074
Martin Memorial Medical Center -- Stuart, FL -- F02212
Mease Countryside Hospital -- Safety Harbor, FL -- F00701
Mease Dunedin Hospital -- Dunedin, FL -- F00702
Memorial Hospital Jacksonville -- Jacksonville, FL -- F01434
Memorial Hospital Miramar -- Miramar, FL -- F02017
Memorial Hospital Pembroke -- Pembroke Pines, FL -- F01992
Memorial Hospital West -- Pembroke Pines, FL -- F02335
Memorial Regional Hospital -- Hollywood, FL -- F02481
Mercy Hospital (Miami) -- Miami, FL -- F01859
Morton Plant Hospital -- Clearwater, FL -- F00700
Morton Plant North Bay Hospital -- New Port Richey, FL -- F00699
Mount Siani Medical Center -- Miami Beach, FL -- F02070
Munroe Regional Medical Center -- Ocala, FL -- F02356
NCH Healthcare System -- Naples, FL -- F02274
North Florida Regional Medical Center -- Gainesville, FL -- F02362
North Ridge Medical Center -- Fort Lauderdale, FL -- F01301

North Shore Medical Center -- Miami, FL -- F01302
Northside Hospital & Heart Institue -- St. Petersburg, FL -- F01208
Northwest Medical Center -- Margate, FL -- F01537
Oak Hill Hospital -- Brooksville, FL -- F01515
Ocala Regional Medical Center -- Ocala, FL -- F01533
Orange Park Medical Center -- Orange Park, FL -- F01136
Orlando Regional Lucerne Hospital -- Orlando, FL -- F02278
Orlando Regional Medical Center -- Orlando, FL -- F00693
Orlando Regional Sand Lake Hospital -- Orlando, FL -- F02676
Orlando Regional South Seminole Hospital -- Longwood, FL -- F02663
Palm Bay Community Hospital -- Palm Bay, FL -- F00508
Palm Beach Gardens Medical Center -- Palm Beach Garden, FL -- F01304
Palmetto General Hospital -- Hialeah, FL -- F01305
Palms West Hospital -- Loxahatchee, FL -- F01625
Parkway Regional Medical Center -- North Miami Beach, FL -- F01307
Pasco Regional Medical Center -- Dade City, FL -- F02534
Pinecrest Rehab Hospital -- Miami, FL -- F01309
Plantation General Hospital -- Plantation, FL -- F01571
Raulerson Hospital -- Okeechobee, FL -- F02051
Regional Medical Center Bayonet Point -- Hudson, FL -- F01944
Sacred Heart Health System -- Pensacola, FL -- F00170
Sacred Heart Hosp. of Emerald Coast -- Destin, FL -- F01755
Santa Rosa Medical Center -- Milton, FL -- F02537
Sarasota Memorial Hospital -- Sarasota, FL -- F00064
Sebastian River Medical Center -- Sebastian, FL -- F02925
Seven Rivers -- Crystal River, FL -- F02526
Shands at AGH -- Gainesville, FL -- F01027
Shands at Starke -- Starke, FL -- F02957
Shands at the University of Flordia -- Gainesville, FL -- F02280
Shands Jacksonville -- Jacksonville, FL -- F01123
Shands Lake Shore -- Lake City, FL -- F02891
Shands Live Oak -- Live Oak, FL -- F02890
Shands Rehab Hospital -- Gainesville, FL -- F02893
Shands Vista -- Gainesville, FL -- F02892
South Bay Hospital -- Sun City Center, FL -- F01347
South Florida Baptist Hospital -- Plant City, FL -- F00698
South Miami Hospital -- Miami, FL -- F00561
Southwest Florida Regional Medical Center -- Fort Myers, FL -- F01636
Specialty Hospital jacksonville -- Jacksonville, FL -- F01400
St. Anthony's Hospital -- St. Petersburg, FL -- F00703
St. Joseph's Hospital -- Tampa, FL -- F00697
St. Lucie Medical Center -- Port St. Lucie, FL -- F01408
St. Luke's Hospital -- Jacksonville, FL -- F01493
St. Mary's Medical Center -- West Palm Beach, FL -- F01326

St. Petersburg General Hospital -- St. Petersburg, FL -- F01254
St. Vincent's Medical Center, Inc. -- Jacksonville, FL -- F01734
Sun Coast Hospital Inc. -- Largo, FL -- F02071
Tallahassee Memorial Healthcare, Inc. -- Tallahassee, FL -- F00159
Tampa General Hospital -- Tampa, FL -- F02376
The Children's Hospital of Southwest Florida -- Fort Myers, FL -- F02506
Twin Cities Hospital -- Niceville, FL -- F01411
University Community Hospital - Carrollwood -- Tampa, FL -- F02373
University Community Hospital - Medical Center -- Tampa, FL -- F01437
University Hospital and Medical Center -- Tamarac, FL -- F02037
Venice Regional Medical Center -- Venice, FL -- F02532
West Boca Medical Center -- Boca Raton, FL -- F01333
West Florida Hospital -- Pensacola, FL -- F01370
Westside Regional Medical Center -- Plantation, FL -- F01358
Winter Haven Hospital -- Winter Haven, FL -- F00077
Wuesthoff Medical Center - Melbourne -- Melbourne, FL -- F02552
Wuesthoff Medical Center - Rockledge -- Rockledge, FL -- F02551



INSTITUTE FOR HEALTHCARE IMPROVEMENT

How health care organizations are connecting the dots between concept and positive results

ideas *in Action*

2005 PROGRESS REPORT

ideas

Real, meaningful, lasting change usually springs from a simple idea, a single inspirational source.

A novel approach can spark waves of innovation that ultimately lead to breakthrough results never before imagined.

in

The Institute for Healthcare Improvement (IHI) helps accelerate change in health care by cultivating promising concepts for improving patient care and turning those ideas into action. Over and over again, we've seen innovative ideas lead to practical solutions that have improved patient care.

This Progress Report is a showcase of some of these success stories – dramatic and measurable improvements – that emanate from modest beginnings. The origins of these stories reveal the exponential power of a single concept to drive widespread change. And the stories themselves show the vast potential of bold individuals and organizations willing to take responsibility for building a better health care system. We are honored to present their successes so the world can see how great health care can be.

This Report is organized around the six aims established for the health care system by the Institute of Medicine. These aims are the barometers of our progress.

For each of these areas, we offer exciting examples of brave institutions that find the status quo unacceptable and are committed to a new level of performance. We hope these stories inspire other health care professionals around the world to take up the charge and turn promising ideas into action.

Action

safe care

SAFETY

IHI launched the Idealized Design of the Medication System initiative in 2000 to develop and test new and safer ways of delivering medication to patients. A year later, more than 50 health care organizations began implementing these innovations in a Breakthrough Series Collaborative called Quantum Leaps in Patient Safety. Now, medication safety is a key area of focus for many of the participants in IHI's IMPACT network, and the change package and supporting tools are available on IHI's website for anyone to put into action.

McLeod Regional Health System in Florence, South Carolina, has a long history of working to improve care. As participants in Pursuing Perfection, a Robert Wood Johnson Foundation program for which IHI serves as the National Program Office, McLeod has been working on many fronts.

One very successful improvement effort has resulted in a dramatic reduction in adverse drug events (ADEs).

"Through our participation in an IHI Collaborative on reducing adverse drug events, we learned about the Trigger tool and that helped us look for errors that cause harm," says Marie Segars, McLeod's Vice President of Patient Services. Although McLeod had been working to reduce ADEs for several years prior to joining the Collaborative, they had reached a plateau and needed new techniques to move the dial further.

"We worked to develop a culture in which everyone was comfortable talking about errors and sharing their own," says Segars, describing a process that can take years. "And we worked with our information systems folks to use technology to improve the reliability of our medication system."

McLeod invested in computerized physician order entry, as well as bar code technology at the bedside that allows nurses to scan the patient's ID bracelet, the medication label, and their own ID badge to verify that they are giving the right medication in the right dose to the right patient at the right time. Automated dispensing of medications on the units also serves as a reliability check and reduces the amount of time it takes to get patients their medication. "We used to average 92 minutes to get a patient the first dose of a new medication," says Segars. "Now we average seven minutes."

time to first medication dose
from 92 minutes to 7 minutes

50% reduction in adverse drug events

OSF HealthCare, with six hospitals in Illinois and Michigan, has been especially successful at reducing harm from medication errors, reducing ADEs by 50 percent. OSF, an IHI IMPACT member, used the four-level approach recommended by IHI: transform the culture to embrace "systems thinking," improve medication reconciliation, focus on safe handling of high-risk medications, and streamline dispensing mechanisms to reduce errors.

At OSF St. Joseph's in Bloomington, IL, mortality rates have dropped significantly due to a number of quality initiatives, and Safety Officer John Whittington, MD, says medication safety measures have played an important role. Whittington credits two specific things: better dispensing mechanisms and a remarkable culture of trust between physicians and pharmacists.

Medication carts have been replaced by an automated medication dispensing system that enters data automatically into the patient's electronic medical record as it accurately dispenses the medication. Through another automated system, pharmacists double-check all physician-ordered medications, looking particularly for medications or doses that might compromise renal function. If such an order is found, pharmacists are authorized to change the medication or dosage without consulting the physician. "This is a new kind of trust that reflects a transformed culture," says Whittington.

75% reduction in discrepancies on medication orders

At Luther Midelfort-Mayo Health System, a large hospital-based physician group in northwest Wisconsin and an IHI IMPACT member, a nurse's hunch has led to dramatic reductions in potential ADEs, as well as new standards designed to help hospitals throughout the nation follow suit.

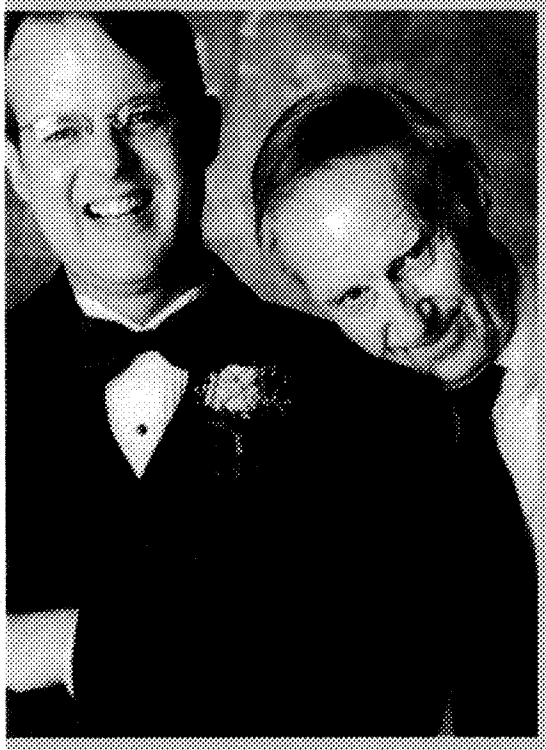
"I knew we needed a way to reconcile patients' medications when they are admitted, transferred, and discharged," says Jane Justesen, RN, Director of Medical Telemetry and Intermediate Care at Luther Midelfort. Every patient hand-off was another opportunity for confusion about medications, she says.

Justesen's hunch was right: A review of patient records revealed that medications not reconciled at transition points may account for as many as 50 percent of all medication errors and up to 20 percent of ADEs. So a quality improvement team used IHI improvement techniques to create an accurate list of all medications a patient is taking and compared that list to the physicians' admission, transfer, and/or discharge orders. The effort has led to a 75% reduction in discrepancies on medication orders.

As the rate of ADEs at Luther Midelfort began to drop, IHI and others paid attention and began to spread the improvement idea to other organizations. It has caught on: The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) plans to add medication reconciliation standards for all hospitals in 2005.

effective care saves lives

EFFECTIVENESS



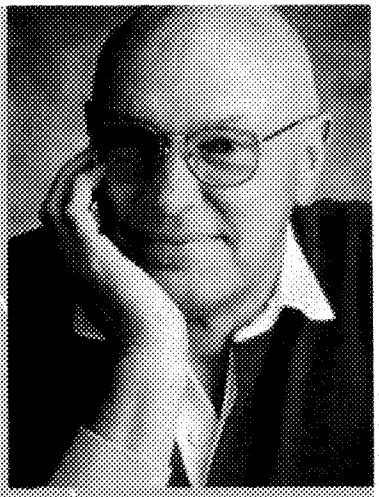
23% decrease in mortality

Tallahassee Memorial HealthCare in Tallahassee, Florida, is the kind of hospital you want to be in if you suffer a life-threatening event such as a heart attack or stroke. Their track record on saving these patients is very good. But it wasn't always that way.

"When Sir Brian Jarman calculated mortality rates for all the Pursuing Perfection hospitals, ours was the highest," recalls Winnie Schmeling, PhD, RN, Vice President of Organizational Improvement and Planning and executive-in-charge of Pursuing Perfection. "So we took on the whole issue of mortality in a very intense way."

Careful reviews of hospital deaths revealed three areas in need of improvement: communication, rescuing, and planning. Failures in these areas are seldom the cause of death, but often contributors.

Through months of study and testing, Tallahassee staff implemented proven strategies to address each area. "We use a set communication framework — Situation-Background-Assessment-Recommendation (SBAR) — to discuss patients," says Pam Folsom, RN, BSN, MS, Manager of Performance Measurement. "We have a Medical Emergency Team (or Rapid Response Team) available 24/7 to consult with any provider who is concerned about a patient. And we use multidisciplinary rounds to plan case management strategies. We took a systems approach to reducing mortality, rather than a diagnosis-specific approach, and it has paid off. We've had a 23 percent decrease over the past three years."



At BAPTIST MEMORIAL HOSPITAL–MEMPHIS in Memphis, Tennessee, an IHI IMPACT member hospital, a new program has helped staff prevent medical crises and reduce patients' risk of dying.

In order to intervene more consistently with patients before a medical crisis, Baptist-Memphis has deployed a Rapid Response Team (RRT). The team is composed of a critical-care trained nurse, a respiratory therapist, and, when available, an intensivist physician. On call 24 hours a day, the team helps any provider assess patients' symptoms and initiate interventions to prevent a serious medical problem.

Virtually all critical inpatient events are preceded by warning signs for several hours. RRTs use this window of time to rescue patients before they develop serious medical problems.

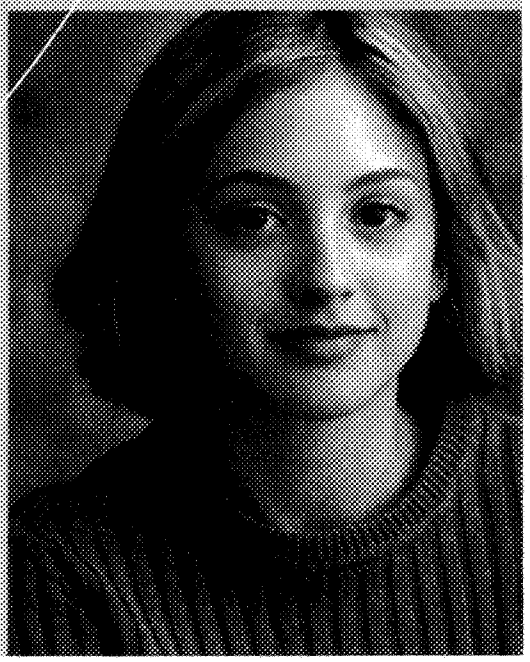
The Baptist-Memphis RRT averages about 21 calls per week. Since the introduction of the program, the number of Code Blue calls has dropped by 28 percent. The location of Codes has changed as well: prior to RRTs, 65 percent of Codes were on med/surg units. Today, the majority of Codes are in the ICU, indicating that the highest risk patients are in the proper setting, getting the highest level of care available.

28% reduction in Code Blue calls

As participants in the Pursuing Perfection initiative, a Robert Wood Johnson Foundation program for which IHI serves as the National Program Office, BRACKENRIDGE UNIVERSITY MEDICAL CENTER (HUMC) has focused on improving care for patients with acute myocardial infarction (AMI). The effort centered both on treatment of AMI patients and secondary prevention.

Because speed is crucial in the treatment of AMI patients, HUMC worked with its hospital-based paramedics to provide digital EKGs to the emergency department while still en route. Now, when patients arrive, emergency department physicians can initiate the ED's "thrombopage system," which simultaneously pages the Cath Lab and interventional cardiologist when an EKG indicates a dangerous weakening of the heart muscle.

The staff also developed a case review process to provide feedback and help increase compliance with evidence-based guidelines for secondary prevention of AMI. The chief physicians of the cardiac ICU and the emergency department lead AMI rounds, during which participants review recent AMI cases. When system-based problems are identified, staff perform a root cause analysis and test changes for improvement.



mortality due to AMI significantly below national average

bundling up for better outcomes

EFFECTIVENESS

At the VETERAN'S ADMINISTRATION BOSTON HEALTHCARE SYSTEM the rate of surgical site infections and other types of perioperative harm has dropped dramatically in the past year, thanks to implementation of a bundle of perioperative interventions learned in an IHI Collaborative.

By instituting deep vein thrombosis (DVT) prophylaxis steps, beta blockade to prevent cardiac events, timely prophylactic antibiotic administration to prevent surgical site infections, and pre-procedural briefings to foster teamwork and communication, the VA Boston reduced their perioperative harm rate in a pilot population by 50 percent, cut unplanned surgical readmits from 4.5 percent to 3.03 percent, and reduced unplanned returns to the OR from 1.3 percent to 0.03 percent.

"Administering an antibiotic to patients within an hour before the surgical incision sounds simple, but it's actually pretty complicated," says Debra Furlong, RN, MS, Clinical Coordinator for Surgical Services. "Patients don't arrive at the OR from the same place. Some come from the wards, some from the ED and some from home, and you have to coordinate for all of them. Also, some patients are allergic to penicillin and require an entirely different antibiotic regimen."

Furlong says monitoring the appropriate use of the interventions is an important ongoing job. "You can never sit back and say we're done," she says. "We are always fine-tuning things to see how we can continue to improve."

50% drop in perioperative harm

mortality from sepsis dropped from 60% to 25%

By implementing a specific bundle of treatment steps, IHI IMPACT member STRONG MEMORIAL HOSPITAL in Rochester, New York, part of the University of Rochester Medical Center, has been winning its fight against an evasive and tenacious enemy: sepsis.

In North America, sepsis kills more people in a year than breast cancer, lung cancer, and colon cancer combined. At Strong Memorial, use of the sepsis bundle has begun to make a significant difference. Mortality from sepsis dropped from 60 percent to 25 percent in three months. This is no small feat. Implementing the sepsis bundle requires a great deal of focus and coordination.

For patients with severe sepsis, as many as eight steps must be accomplished within the first six hours of presentation. "Time is tissue," says Barry Evans, NP Critical Care Data Coordinator at Strong. "You need to respond rapidly to have good outcomes."

Sepsis itself is a whole-system problem, and so is its remedy: education and training must be systemwide, says Evans. "Patients are often diagnosed on the wards or the ED, and treatment must begin immediately, before the patient moves to the ICU. Getting this right involves improving patient flow, communication, and clinical response time. It involves a lot of coordination, collaboration, and determination."

The steps involved in creating the ideal ICU are obvious. But that doesn't mean it's easy, says Lee Vanderpool, Vice President at DOMINICAN HOSPITAL, a 179-bed community hospital that serves Santa Cruz County in California. Part of the 41-hospital Catholic Healthcare West system, Dominican is a member of IHI's IMPACT network.

As a result of its focus on improving critical care processes, Dominican has significantly reduced the average length of stay in the ICU, average ventilator days, and adverse events such as ventilator-associated pneumonia (VAP) and catheter-related blood stream infections.

"We have used multiple tactics to improve care in the ICU," says Vanderpool. "We've implemented the ventilator bundle, daily goal sheets, daily multidisciplinary rounds using the goal sheets as checklists, and aggressive insulin control protocols."

The ventilator bundle calls for the head of the bed to be elevated at 30 degrees, prophylactic care for peptic ulcer disease and deep vein thrombosis, a "sedation vacation," and a daily screening of respiratory function followed by trials of "spontaneous breathing." Because of its use of the bundle, Dominican has experienced only one VAP case in 2004 (as of November).

only one case of VAP in eleven months

patients as partners

PATIENT-CENTEREDNESS

USING AN INTENSE BRAINSTORMING METHOD KNOWN AS A "DEEP DIVE," PIONEERED BY AN INNOVATION COMPANY CALLED IDEO, A GROUP OF IHI EXPERTS TOOK UP THE CHALLENGE OF TRANSFORMING THE EXPERIENCES OF PATIENTS AND STAFF IN AREAS ACROSS MEDICAL CENTER LEADERS OF THE ROBERT WOOD JOHNSON FOUNDATION-FUNDED INITIATIVE CALLED TRANSFORMING CARE AT THE BEDSIDE (TCAB) VISITED HOSPITALS AND SPOKE DIRECTLY WITH PATIENTS AND STAFF. SOME OF THE INNOVATIONS THAT EMERGED ARE BEING TESTED AND IMPLEMENTED IN 15 TCAB PILOT SITES.

At the UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC) – SHADYSIDE in Pittsburgh, Pennsylvania, the concept of "comfort food" has inspired changes in patients' diet options that have not only improved patient satisfaction, but have resulted in better nutrition as well.

"As part of our TCAB work, we surveyed patients to describe what a perfect patient experience would be," says Susan Martin, BSN, MSN, Director of Nursing Support Services. "Many responses focused on improvements in food service." UPMC Shadyside staff recognized that, in many cases, the value of meeting patients' food preferences might outweigh whatever small health-related benefits could be gained from a restricted diet during their hospital stay.

The nutrition staff responded by creating a liberalized diet program, loosening restrictions and extending kitchen hours. An evening snack is also offered to all patients, ranging from yogurt to fruit to brownies.

The changes have resulted in a 42 percent increase in the number of patients who rated the service as exceeding or greatly exceeding their expectations; a 42 percent increase in the number of patients who consumed 75 percent or more of the food on their trays; and, ironically, a 10 percent increase in the number of patients selecting appropriately for their prescribed diet.

In addition, nutrition staff monitor the choices patients make and use the information to educate patients during discharge planning. This has generated a significant increase in educational opportunities about nutrition.

42% increase in patient satisfaction

tenfold decrease in patient falls

Reducing patient falls is clearly a safety improvement, but it is also patient-centered. "There is nothing worse for patients than to restrain them," says Sandy Sharon, Assistant Administrator for Patient Care Services at KAISER FOUNDATION HOSPITAL – ROSEVILLE, in Sacramento, California. "But that's what we sometimes had to do to keep patients safe." Elderly patients are particularly at risk, and a fall in this population can be devastating.

At Kaiser Roseville, a TCAB pilot site, the staff has worked on an array of initiatives to improve patient satisfaction with their hospital experience. One highly successful effort has focused on reducing patient falls by implementing patient safety rounds throughout the hospital.

"We recognized that during changes in nursing shifts, no one was routinely checking on patients," says Sharon. Now, nursing assistants perform safety rounds every two hours and during the beginning and end of shifts, checking to see that beds are in the low position and escorting patients to the bathroom or elsewhere if needed.

"Before this program, we were running as high as five falls per 1000 patient days," says Sharon. "The national benchmark is two falls per 1000 days. Now, we are at 0.5. We haven't had a fall in more than 60 days, and when we get to 90 days, we're going to have a big celebration."

matching nurse capacity with patient needs

As a TCAB pilot site, SETON NORTHWEST HOSPITAL in Austin, Texas, part of the Ascension Health System, has tested a number of changes designed to improve outcomes, patient satisfaction and support the vitality of caregivers. One in particular holds the potential to do all three.

Based on innovative work first developed at Luther Midelfort-Mayo Health System in Eau Claire, Wisconsin, Seton Northwest nurses developed a traffic-light system to declare their availability for additional patient care. At four check-in times during each shift, front line nurses indicate on a centrally located whiteboard their capacity to care for new admissions. This declaration is not based on available beds, but rather on available care. A green magnet shows they are able to take on new patients; yellow means they are nearing capacity; and red means they cannot safely accept another patient.

"The TCAB floor is a very busy 64-bed unit that gets 15 to 20 admissions a day," says Mary Viney, Director of Patient Care Services. Previously, the bed placement coordinator assessed each nurse's workload individually every two hours. "It was a slow, one-on-one process," says Viney.

Not only is the new process efficient, but displaying the information publicly has created a stronger sense of teamwork among nurses, who pitch in to help when they see a colleague is overloaded. This is certainly good for nurses, but even better for the patients they serve.

timing is everything

TIMELINESS

Mark Murray, MD, is a hero to anyone who has ever wanted to see a doctor but couldn't get an appointment for weeks. Murray had the same reaction that most patients have: there must be a better way. So he engineered a concept called open access, in which each day's schedule is mostly open and fills like a glass from the bottom up. Patients can get appointments on the day they call, and providers try to address all the patients' needs during each visit to reduce follow-up visits. IHI embraced Murray's concept, and began to teach it to practices throughout North America and Europe.

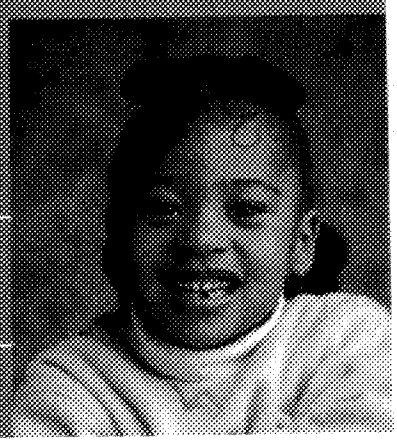
70% reduction in waiting times for a general practitioner

If you wish to launch the largest health improvement program in the world, you'd better think big, because Great Britain's NATIONAL HEALTH SERVICE (NHS) will be hard to top. In 2000, IHI launched its National Primary Care Collaborative, designed to improve access and services in practices throughout the entire nation, with assistance from IHI.

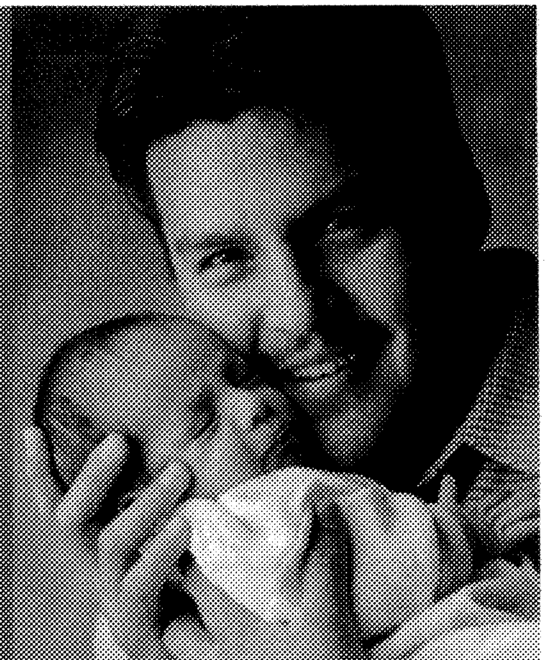
Eighty Primary Care Trusts (PCTs) — regional bodies of the NHS that include dozens of practices — participated in the initial wave of the project. Four years later, more than 1,000 practices have been involved, serving nearly 13 million patients. Success on several fronts has been dramatic, including improved access to primary care where data show a 70 percent reduction in waiting times for general practitioners (GPs) and a 33 percent reduction in waiting times for nurses. The average waiting time to see either type of practitioner is currently only one day.

Using the access model taught by IHI, practices balance appointment capacity and demand on a daily basis and are able to offer patients a choice of ways to access appropriate health care at a time they need it. Both patient and staff satisfaction have increased as waiting times have decreased.

The improvements in these practices are impressive, and the techniques they use are being spread to every PCT in the country.



Double-digit growth in demand for CT scans was both good news and bad news for THEDACARE, a Wisconsin-based health organization that owns both Appleton Medical Center in Appleton and Theda Clark Medical Center in Neenah, 10 miles away. "There was usually a two- to three-week wait for outpatient access," says Steve Carson, Manager of Diagnostic Imaging at ThedaCare.



So ThedaCare, an IHI IMPACT member, put its experience at improving access in primary care to work on improving access to imaging services, including CT scans, MRIs, ultrasounds, and mammograms.

The improvement team included all the stakeholders of the CT department, including ER physicians, nurses, technologists, radiologists, central scheduling, and IT. The team worked toward three primary objectives — opening the schedule, improving patients' readiness and information flow, and examining and restructuring staff roles and responsibilities.

Today most patients who need CT scans are seen the same day if desired, and other imaging appointments are generally available within just a few days. In addition, streamlining the process has allowed ThedaCare to increase its capacity for CT scans, MRIs, ultrasounds, and mammograms.

reduced wait for CT scans from three weeks to same day

Change is never easy, especially for large multi-site practices where daily needs require full attention. But two large practices proved that the effort to change the status quo is energy well spent.

Using the open access scheduling model they learned in IHI collaboratives, IOWA HEALTH PHYSICIANS (IHP), with 55 sites in Iowa and Illinois, and BELLIN MEDICAL GROUP, with 19 locations throughout Northeastern Wisconsin and Michigan's Upper Peninsula, are among the many medical practices that have dramatically reduced the amount of waiting time for routine appointments.

Moving toward open access is hard work, typically requiring extra time and effort to clear the schedule. "We added extra slots for a while to work down our backlog," says Mark Barnhill, DO, IHP's Medical Director. "We also reduced appointment types and evaluated the reasons for return visits."

Bellin followed a similar strategy, temporarily extending hours, simplifying scheduling templates, redesigning care teams, and implementing alternatives to one-on-one care. "First we had to convince the staff that this was possible," says Randi Burnham, NP, Bellin's Team Leader for Clinical Services. "Then, it was a matter of working hard to get there."

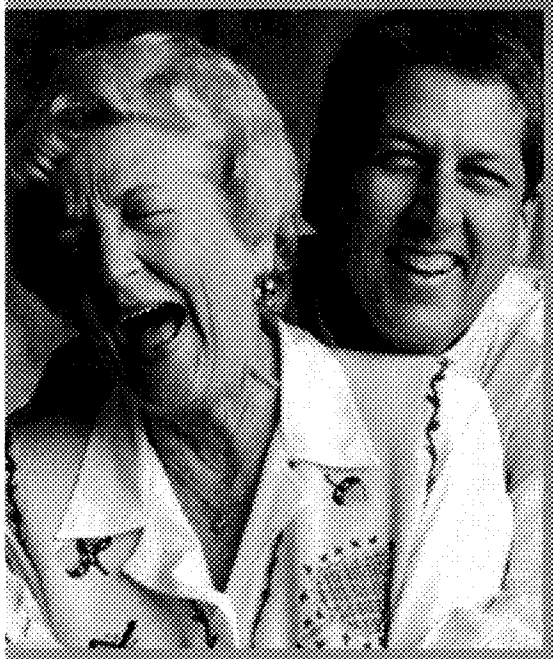
Gradually, but steadily, both groups reduced the time to the third next appointment (a standard measure of access) in their pilot sites to same-day access in the vast majority of practices. Now, Bellin has open access in all its sites, and Iowa is well on its way toward that goal.

most appointments available same day

bringing lessons from the outside in

EFFICIENCY

HEALTH CARE ORGANIZATIONS ARE COMPLEX SYSTEMS THAT OFTEN BY INVISIBLE PROCESSES, UNITS, AND DISCIPLINES DO CARE FOR PATIENTS. IHI ALWAYS URGES GROUPS THAT COME TOGETHER IN A SMOOTH AND SEAMLESS FASHION TO PROVIDE EFFECTIVE CARE. BUT THE IDEAL IT SEEMS IS NOT NECESSARILY THE NORM IN HEALTH CARE. OTHER INDUSTRIES HAVE MUCH TO TEACH HEALTH CARE ABOUT CREATING SMOOTH PROCESSES AND MINDSETS. IHI HAS SOUGHT TO INFUSE HEALTH CARE WITH MANAGEMENT CONCEPTS THAT ARE SUCCESSFULLY USED BY COMPANIES AS DIVERSE AS McDONALD'S, TOYOTA, AND DISNEY.



Opportunity: Manage Flow in Health Care

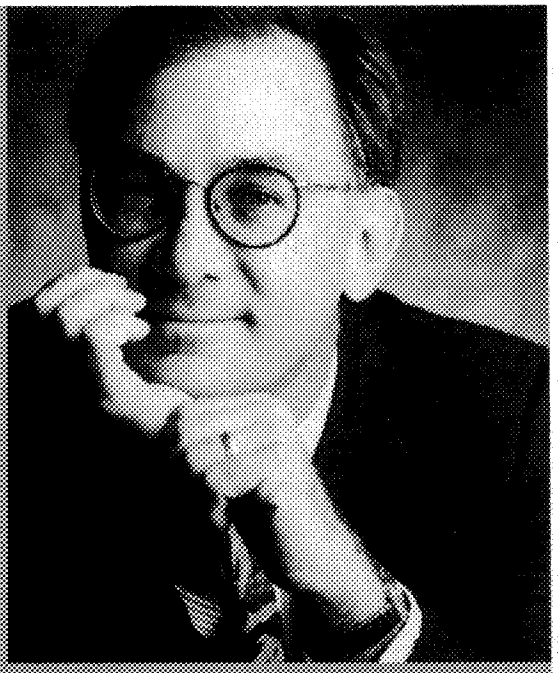
96% of ED patients admitted or discharged within 4 hours

Things used to get so backed up at THE ROYAL DEVON AND EXETER NHS FOUNDATION TRUST (RD&E) an 850-bed hospital in the United Kingdom, that word would periodically spread throughout the community to stay away. Patients who came anyway would wait for hours and hours in the emergency department (ED), and those who were admitted were often placed in inappropriate settings. Ironically, patients would also wait excessively just to be discharged.

Today, that picture couldn't be more different as more than 96 percent of patients seen in the ED are admitted or discharged within four hours. This is thanks to a comprehensive improvement effort launched by The North and East Devon Health and Social Care Community which runs the hospital. The organization is a participant in Pursuing Perfection, a Robert Wood Johnson Foundation initiative for which IHI serves as the National Program Office.

Efforts to improve patient flow into and out of RD&E centered on each end of the inpatient experience: admissions and discharge. An Access Team was created to triage patients who arrived at the ED but did not require acute care, arranging for appropriate care elsewhere. Discharge planning became a priority, as did the streamlining of support systems such as transport and prescription filling.

Inappropriate admissions are also on the decline. Where it used to be typical to have more than 60 medical outliers (medical patients placed in surgical beds necessitating the cancellation of elective surgeries) on any given day, now RD&E rarely has any, something they believe no other hospital in England can claim.



45% decrease in surgeries performed after 3pm

With about 25,000 surgical cases per year, ST. JOHN'S REGIONAL HEALTH CENTER in Springfield, Missouri fully utilized its 22 operating rooms (ORs), often late into the night. But that was the problem: The surgical schedule was often thrown way off by emergencies or other unplanned surgeries, pushing the day's scheduled cases later and later.

For Christine Dempsey, BSN, CNOR, Vice President of Perioperative Services at St. John's, the solution came with crystal clarity when she attended an IHI Collaborative session on improving patient flow. "I heard some really fascinating and exciting ideas, with compelling evidence," she recalls. The answer to St. John's OR scheduling problems, she learned, was to set aside one OR for unplanned surgeries only.

She offered her skeptical surgeons evidence she had learned in the Flow Collaborative from IHI faculty member Eugene Litvak, PhD. Unscheduled surgeries, said Litvak, are actually more predictable than elective procedures.

Seeing is believing: with a separate OR for unscheduled cases, St. John's has seen a five-percent increase in surgical case volume, a 45 percent decrease in surgeries performed after 3 PM, an all-time low in OR overtime, a 4.6 percent increase in revenue, and improved staff and patient satisfaction.

emergency department diversions eliminated

When a hospital emergency department routinely goes on diversion — temporarily closing due to lack of capacity — it is usually an indication of systemwide problems. This was the case at CAMDEN-CLARK MEMORIAL HOSPITAL (CCMH) in Parkersburg, West Virginia, which used to divert patients about 20 times per month.

The irony, of course, is that diverting patients requires its own set of steps. "We were spending a lot of time and effort turning patients away," says Jessica Owens, BSN, RN, CEN, Clinical Specialist and Trauma Coordinator at CCMH.

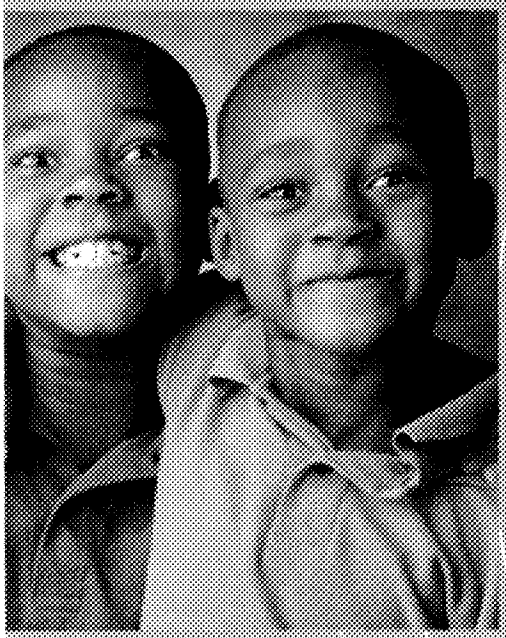
With 30 beds and about 48,000 visits per year, the flow of patients into the ED is steady, says Owens. But it was the flow out of the ED, she says, that was the real problem. As participants in an IHI Collaborative on improving patient flow, CCMH staff learned to analyze patterns and get to the root cause.

"We were diverting patients not because we couldn't treat them in the ED, but because we couldn't move them out of the ED quickly enough," says Owens.

The team launched several efforts to improve flow, including better models for determining bed needs, faster bed turnaround times, and a high-census plan that opens additional patient areas and reschedules surgeries if necessary. Now, it takes a rare event to close the CCMH emergency room. In the past year, the ED has gone on diversion only once, when a car crashed directly into the emergency room bay doors.

equity means everyone

EQUITY



Urban Health Care Center in the South Bronx of New York, a federally funded community health center, serves a predominantly Hispanic population in one of the poorest congressional districts in the country. Asthma is an epidemic in this population, says Sam De Leon, MD, the Center's Chief Medical Officer.

Serving patients in one large clinic and two satellite clinics, as well as five school clinics, two homeless shelters, and one adult day health center, Urban Health logs about 140,000 visits a year. "We wanted to address the needs of our asthma patients so we created an asthma program," says De Leon. Unfortunately, he recalls, not much changed.

"We were motivated, but not educated," he says. They were ripe for participation in the Bureau of Primary Health Care's Health Disparities Collaborative, a program supported by IHI. "When we learned the Chronic Care Model through the Collaborative, we were hooked," he recalls. "It taught us exactly what we needed to take better care of this population."

Today, Urban Health has close to 4,000 patients in its asthma registry and shares credit for a significant drop in asthma hospitalizations in the surrounding population. Among Urban Health's asthma patients, the average number of symptom-free days has increased dramatically and the number of patients classified as severe asthmatics is dropping.

[illegible]% increase in symptom-free days

BIG SANDY HEALTH CARE operates four federally funded community health centers in rural eastern Kentucky. Diabetes is the second most common diagnosis, behind hypertension, among the nearly 15,000 patients the clinics serve.

"We knew we needed to implement evidence-based guidelines for the care of our diabetic patients," says Pat Willis, Big Sandy's Director of Patient Services. "And we did." But they soon discovered that, as Willis says, "having something written on a piece of paper doesn't necessarily mean it gets done."

Through participation in the Health Disparities Collaborative, staff learned how to implement guidelines in effective and practical ways. "The Collaborative helped us figure out how to organize our system to support guidelines," says Willis.

The staff created a computerized patient registry, working from paper records. "We don't have electronic medical records," says Willis, which made it hard to effectively manage care for populations. But the registry has changed that. "We can see which patients have and haven't been in, and we can track data that help us manage their care."

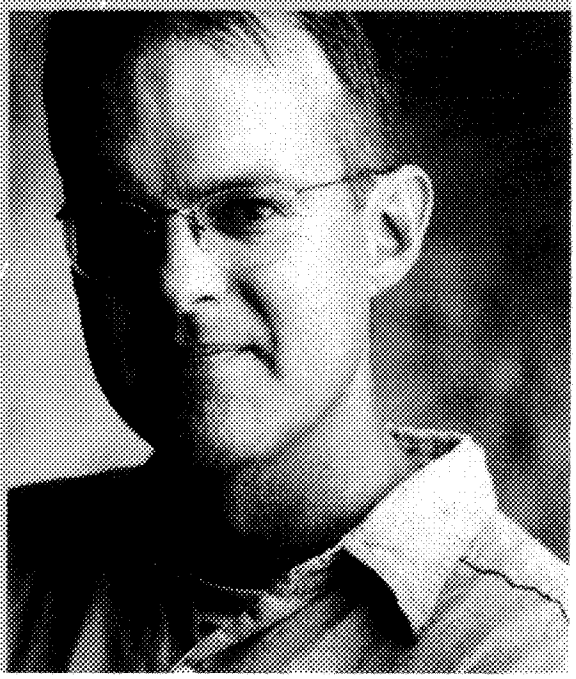
With the average glucose level at 7.1 (against a target of 7), and more than 80 percent of patients with self-management goals, Willis says staff are newly energized. "When we see such improved outcomes, it just thrills us," she says.

80% of diabetic patients have self-management goals

Bringing improvement concepts and chronic care management techniques to developing countries is important and challenging work. In collaboration with Partners In Health and the [illegible], IHI has sought to reduce the burden of tuberculosis (TB) in Peru while creating models for future efforts in other nations. In March 2002, IHI and its partners launched an improvement project that included Peru's 41 health centers and hospitals.

Specific goals of this 18-month Collaborative included improving the cure rate of TB by improving case detection; strengthening clinical protocols; providing clinical management of patients with complications such as malnutrition; developing patient supports that address patients' expressed needs; creating tools for ongoing measurement of TB care; and building care teams around shared principles and values.

But beyond specific goals was a larger one: to plant the seeds of an improvement culture that would take root and grow beyond the project's boundaries. Success wasn't measured just in outcomes — one clinic reported a 200 percent increase in the number of patients in treatment during one reporting cycle — but in the demonstration of government investment and leadership, high-level investment from front-line care sites, and the commitment with which participants embarked on the journey of change.



200% increase in patients receiving treatment

the next generation must carry the torch

Working with a number of national organizations involved in the education of health professionals, AHC is spearheading an academic medical center collaborative to facilitate teaching of competencies for the next generation of doctors and nurses. The work of the collaborative is based on competencies outlined in a report commissioned in 1999 by Paul Gerbers, MD, previously a vice president of the AAMC and currently an AHC fellow, and Paul Batalden, MD, an AHC co-founder and current board member.

Facilitated by Dr. Gerber and Dr. Batalden, the Collaborative began in March 2003 with deans and faculty from six medical schools from across the U.S. Since then, the Collaborative has grown substantially in both size and scope. Sixteen medical schools are currently participating, as are companion schools of nursing and teaching hospital affiliates.

- Case Western Reserve University School of Medicine
- Dartmouth Medical School
- Mayo Medical School
- Michigan State University College of Human Medicine
- Oregon University School of Medicine
- Pennsylvania State University College of Medicine
- University of Chicago School of Medicine
- University of Cincinnati College of Medicine
- University of Connecticut School of Medicine
- University of Louisville School of Medicine
- University of Miami School of Medicine
- University of Minnesota Medical School
- University of Missouri School of Medicine
- University of North Carolina School of Medicine
- University of Tennessee College of Medicine
- Vanderbilt University School of Medicine

The Collaborative has thus broadened its mission to include a focus on student-initiated learning and students as change agents within the academic medical center setting.

As the Collaborative prepares for its third year, its leaders look forward to the challenge of maintaining its mobility, integrating an eclectic group of health professions educators, and broadening its mission to include the development of an infrastructure for inter-professional education.

the movement is gaining momentum

What started as a simple notion and quickly became a fringe movement in health care is now rapidly becoming the mainstream approach to ensuring that the best possible care is delivered to every patient, every day. The impressive results and inspirational stories presented in this report suggest that we are not far from the day when quality improvement is the core business strategy for most health care organizations, as it is in many other industries.

The momentum for change is growing every day. As evidence we offer the following statistics on IHI's programs as of the end of 2004:

- Approximately 4,000 health care leaders from around the world will attend IHI's National Forum on Quality Improvement in Health Care in December 2004 with another 6,000 expected to join via satellite broadcast.
- 2,800 people joined a single phone call on November 12, 2004, to mark the 5th anniversary of the IOM's "To Err is Human" report.
- 15,000 people have subscribed to IHI's monthly electronic newsletter.
- More than 2 million "visits" were logged on IHI's website in 2004.
- 175 organizations have joined IHI's IMPACT network.
- 700 people have graduated from IHI's Breakthrough Series College.
- People from more than 50 countries on six continents are involved in IHI's work.

Without question, the quality improvement movement is gaining momentum in health care. And it will not stop as long as we continue to turn simple ideas into widespread action.

The article you're about to join in the important work of improving health care. The following pages provide an overview of ways you can get involved with IHI.

IHI is here to help

SOME are starting their improvement work by seeking new ideas and acquiring fundamental improvement skills.

OTHERS have made a real commitment to change and are taking action to dramatically improve specific areas of care.

STILL OTHERS have achieved meaningful local successes and are now aiming to achieve whole-system transformation.

Wherever your organization finds itself on its improvement journey, IHI has a program that can help you move to the next level. For more information about any of these programs, visit www.ihi.org or call IHI toll-free at (866) 787-0831.

WEB-BASED RESOURCES

IHI.ORG
IHI's online resource containing all of IHI's improvement knowledge and tools — available free of charge to anyone, anywhere whose aim is to improve health care.

CONFERENCE IMPROVEMENT NEWSLETTER
Our free monthly e-newsletter that includes improvement tips, success stories, and updates on IHI's programs — an excellent way to keep informed.

WEB-BASED LEARNING PROGRAMS
On-line training programs for learning fundamental skills and important improvement concepts at your convenience.

WEBSACTION
A series of web-based learning sessions with practical application assignments between sessions.

CONFERENCE CALL PROGRAMS

STAT CALLS
"Just-in-time" audio conferences for disseminating breaking knowledge, promising approaches, or breakthrough results.

ACCESS TO ACTION® AUDIO CONFERENCE SERIES
A series of conference calls with topic experts, providing all the benefits of a "real" conference without the travel.

ACCESS TO ACTION® FOR JAMA
In partnership with JAMA, a program designed to more rapidly bring clinical evidence into practice by connecting practitioners to authors of JAMA articles.

CONFERENCES

NATIONAL FORUM ON QUALITY IMPROVEMENT IN HEALTH CARE
The premier "meeting place" for people committed to the mission of improving health care.

EUROPEAN FORUM ON QUALITY IMPROVEMENT IN HEALTH CARE
In partnership with the BMJ Publishing Group, an annual meeting for European improvement leaders.

INTERNATIONAL SUMMIT ON PATIENT-CENTERED OFFICE PRACTICE
A showcase of innovations and practical solutions for improving the clinical office practice.

INTERNATIONAL SUMMIT ON IMPROVEMENT IN HOSPITAL CARE
An in-depth exploration of practical ideas for saving lives, time, and money in the hospital setting.

PROFESSIONAL DEVELOPMENT PROGRAMS

PATIENT SAFETY OFFICER EXECUTIVE DEVELOPMENT PROGRAM
An intensive eight-day training to help Patient Safety Officers and others responsible for safety create and lead powerful patient safety programs.

IMPROVEMENT ADVISOR FELLOWSHIP PROFESSIONAL DEVELOPMENT PROGRAM
Nine-month training and support program to develop Improvement Advisors who provide improvement expertise and leadership to health care organizations.

EXECUTIVE QUALITY ACADEMY
An intensive five-day executive program designed to improve the ability of senior leaders to achieve measured quality improvement at the level of whole systems.

OPERATIONS MANAGEMENT IN HEALTH CARE
A seven-month interactive program to help leaders improve operations by applying management techniques not traditionally used in health care.

BREAKTHROUGH SERIES COLLEGE
Training in all aspects of the IHI Breakthrough Series methodology, designed to help organizations rapidly spread improvements.

COLLABORATIVE LEARNING OPPORTUNITIES

BREAKTHROUGH SERIES COLLABORATIVES
Collaborative improvement projects where health care organizations work together and with IHI to rapidly deploy changes that produce breakthrough results in a specific clinical or operational area.

IMPACT NETWORKS
Groups of organizations working together and with IHI to explore novel solutions for improving care where best practices do not already exist or are not fully developed. Open to IMPACT member organizations only.

THE IMPACT NETWORK
IHI's results-driven network for change, providing member organizations a framework for addressing leadership issues while making breakthrough change on the frontline.

about IHI

Our Boston Group

THE INSTITUTE FOR HEALTHCARE IMPROVEMENT (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. Founded in 1991 and based in Boston, Massachusetts, IHI is a reliable source of energy, knowledge, and support for a never-ending campaign to improve health care.

Employing a staff of more than 75 people and maintaining partnerships with over 200 faculty members, IHI offers comprehensive products and services that improve the lives of patients, the health of communities, and the joy of the health care workforce.

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Kendall Regional
Medical Center

Patient Safety at Kendall Regional Medical Center

Miami, Florida

JoAnne Plumlee, RN, MSN, CNA, CNOR, LHRM

Chief Nursing Officer

KENDALL REGIONAL *Medical Center*

Patient Safety Activities

- Part of Mission Statement
- Introduced to all new employees at General Orientation and during Patient Care Orientation
- Patient Safety Plan
- Topic of the Month during each year
- Department Meetings agenda item
- Medical and Nursing Continuing Education activities
- National Patient Safety Awareness Week
- Patient Safety Committee
- Patient Safety Walks
- Medication Safety
- National Patient Safety Goals
- Safety Fair
- Patient Safety Initiatives

Mission Statement

- To deliver quality, compassionate, and cost effective Healthcare services, in a ***safe*** environment, through operational excellence to our West Dade residents, recognizing the cultural diversity of our employees and the community we serve.

Orientation

- New employees, volunteers and students are scheduled to attend orientation on their first work day.
- Orientation includes an introduction to Patient Safety which describes the Patient Safety Plan and National Patient Safety Goals.
- Newly credentialed physicians are provided with the Patient Safety information in their orientation manual.

Patient Safety Plan

- The purpose of the Patient Safety Plan is to improve patient safety and reduce risks to patients through an environment that encourages:
  - Recognition & acknowledgment of risks and medical/health care errors.
  - Initiation of actions to reduce these risks.
  - Internal reporting of medical/health care errors.
  - Minimization of individual blame or retribution for involvement in a medical/health care error with a focus on processes and systems.
  - Organizational learning from medical/health care errors reported and actions taken to prevent recurrence in the future
- The patient safety plan involves *all departments* and *disciplines* in establishing the processes and mechanisms that comprise the patient safety activities at Kendall Regional Medical Center.

Topic of the Month

- Patient Safety is the September Topic of the Month for discussion in each department/unit.
- The patient Safety Plan and Patient Safety activities are reviewed with all hospital employees.

Departmental Meetings

- Patient Safety is an agenda item for discussion at Hospital departmental meetings, Medical Staff meetings, Medical Executive meetings, and the Board of Director Meetings.

Medical and Nursing Education Continuing Education Activities

- Continuing Education Activities include:
  - Prevention of Medical Errors
  - Prevention of Wrong-Site Surgery

National Patient Safety Awareness Week

- National Patient Safety Awareness Week is celebrated each year from March 7 – 13.
- The goal of this week is to provide education and awareness for improving patient safety.
- Each year we participate with a different activity such as: Patient Safety Poster board competition, patient education and Patient Safety Advocate award.


SAFETY
Good Job
It's All In Our Hands

Patient Safety Awareness Week Proclamation

Patient Safety Committee

- This is a medical staff committee that meets on a quarterly basis to review all hospital data related to Patient Safety.

- **Members include:**
  - CEO
  - Chief of Medical Staff
  - Two Physicians
  - Quality Manager
  - Hospital Risk Manager
  - CNO
  - Pharmacy Director
  - Patient Safety Officer
  - Infection Control Coordinator
  - Certified Physician Risk Manager
  - Community lay member

Patient Safety Walks

- Patient Safety Walks are conducted by the administrative team.
- The administrative team visits with clinicians in their work area to discuss patient safety.
- The goal is to encourage an open environment for patient safety communication and continue the development of KRMC's **"Culture of Patient Safety"**

Medication Safety

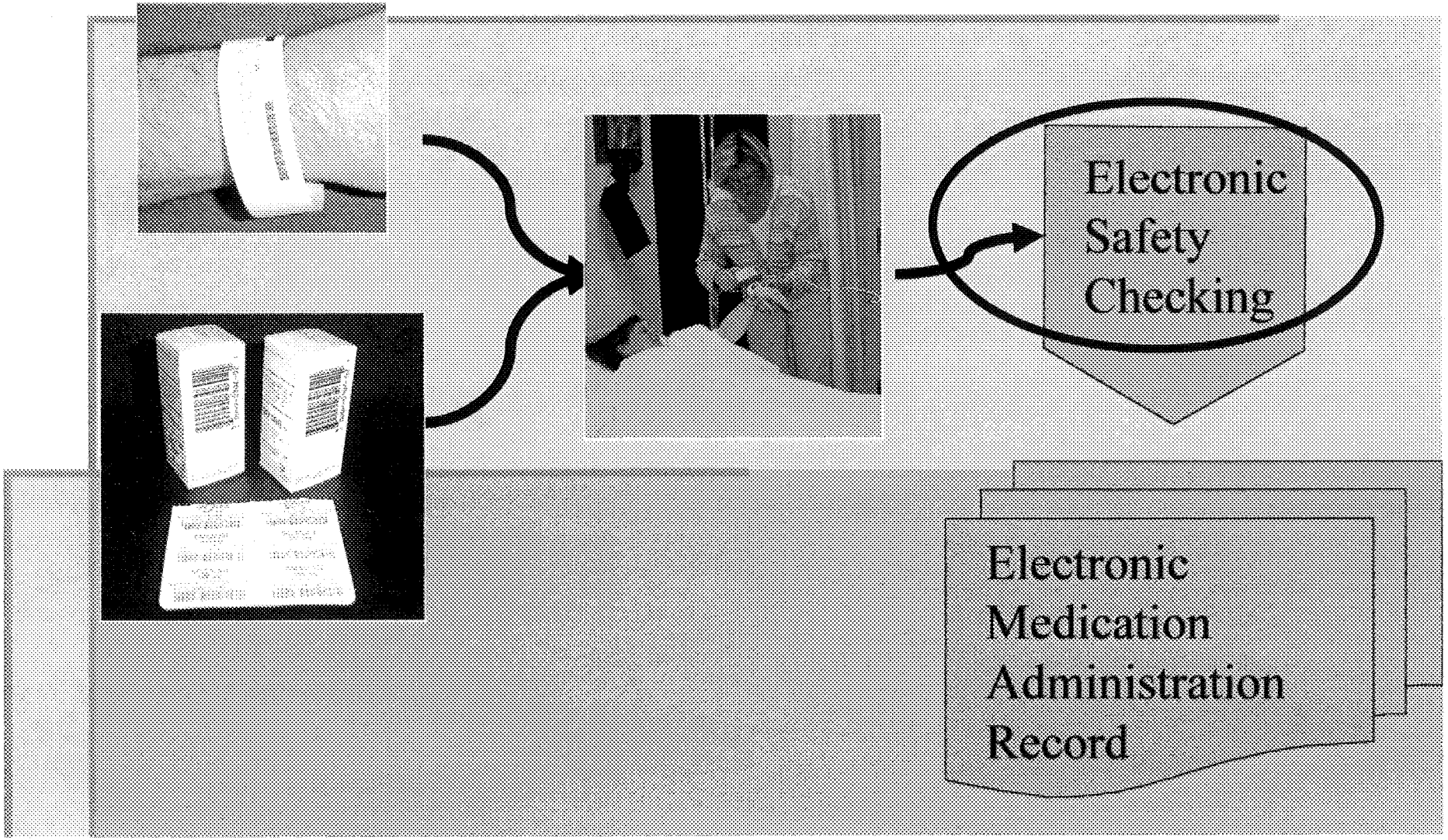
- KRMC is committed to the reduction of medication errors through the use of Technologies:
  - SPOC
    - "Servicing Patients On Command": McKesson Robotic Medication Dispensing System
  - eMAR & Bar Coding
    - Electronic medication administration record
    - Bar code scanner for medication and patient's identification band.
  - ePOM
    - Electronic provider order management
    - Projected Implementation: 2007

SPOC
(Servicing Patients On Command)

*e*MAR & Bar Coding

- e - lectronic
- M - edication
- A - dministration
- R - ecord

eMAR & Bar Coding Is . . .



Expected Outcomes

- Fewer medication administration errors
- More complete documentation
- Staff perception of improved safety
- Patient perception of improved safety
- Improved accuracy of billing

ePOM system developed to erase prescription errors

Southern Hills testing new technology that would make reading doctor's writing a thing of the past.

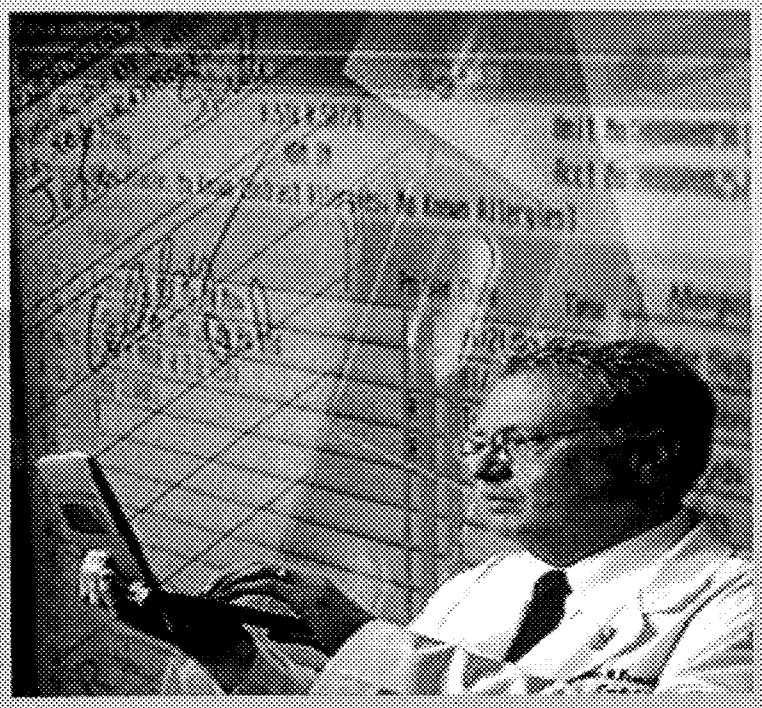
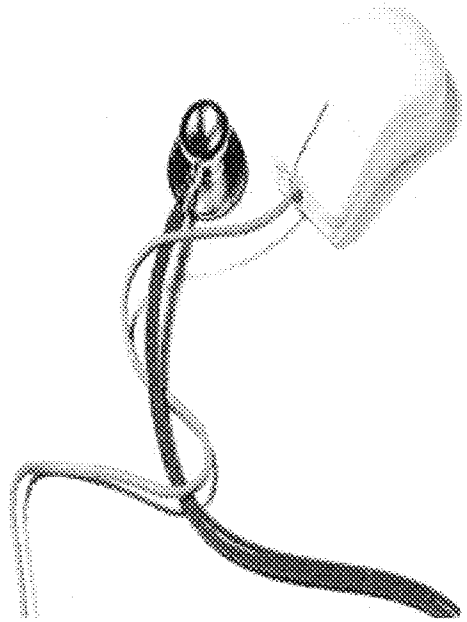


PHOTO ILLUSTRATION BY LARRY MCCORMACK / STAFF
Dr. Jerry Franklin soon will be sending his prescriptions to the Southern Hills Medical Center's pharmacy using a hand-held wireless computer.

ePOM Goals



- Reduce prescribing errors and injury to patients
- Support clinical decision making
- Improve timeliness of care
- Improve quality of care

Benefits for Physicians

- Up-to-date clinical data available during ordering
- Phone calls clarifying handwriting, interactions, allergies, backorders, etc. eliminated
- Discharge and transfer ordering faster
- Time to treatment reduced

National Patient Safety Goals

- KRMC adheres to the JCAHO National Patient Safety Goals through implementation and tracking and trending for compliance.

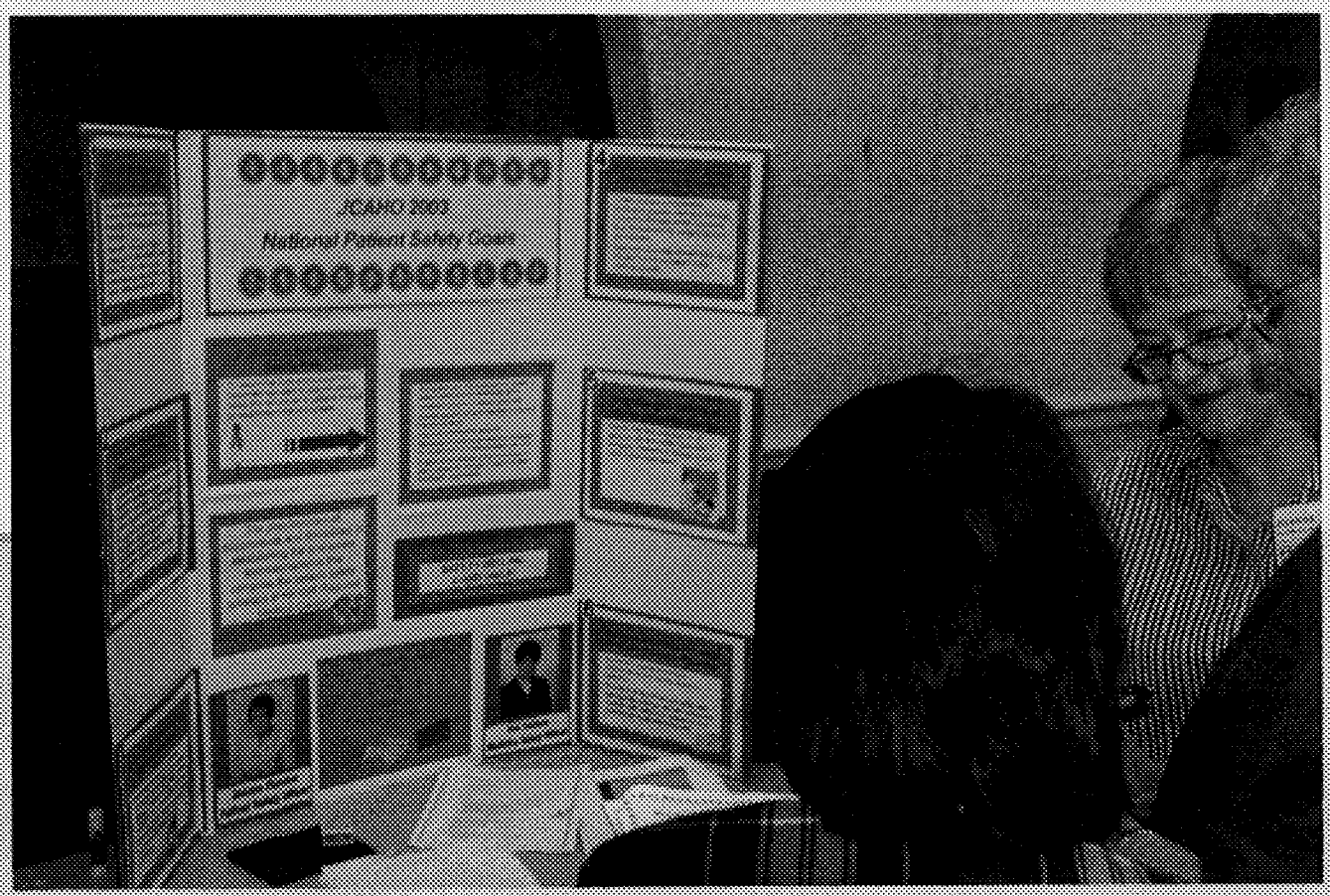
2006 National Patient Safety Goals

- Improve the accuracy of patient identification.
- Improve the effectiveness of communication among caregivers.
- Improve the safety of using medications.
- Reduce the risk of health care-associated infections.
- Accurately and completely reconcile medications across the continuum of care.
- Reduce the risk of patient harm resulting from falls.

Safety Fair

- KRMC conducts an annual Safety Fair which includes Environment of Care and Patient Safety information.
- Employees participate by attending each exhibit for an inservice and *hands-on* demonstrations.
- At the conclusion of the employees' visit at the safety fair, they complete and submit their test.

Safety Fair

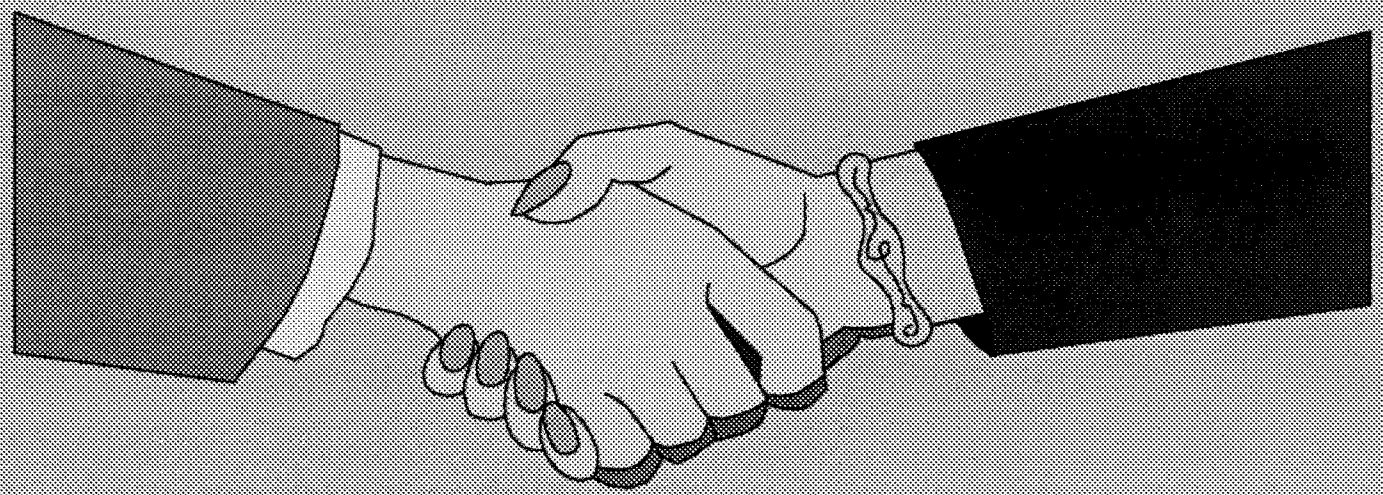


Patient Safety Initiatives

- KRMC participates in several Patient Safety Initiatives which include:
  - Leap Frog
  - Institute for Healthcare Improvement, IHI (100,000 lives Campaign)
  - The American Hospital Quest for Quality Prize

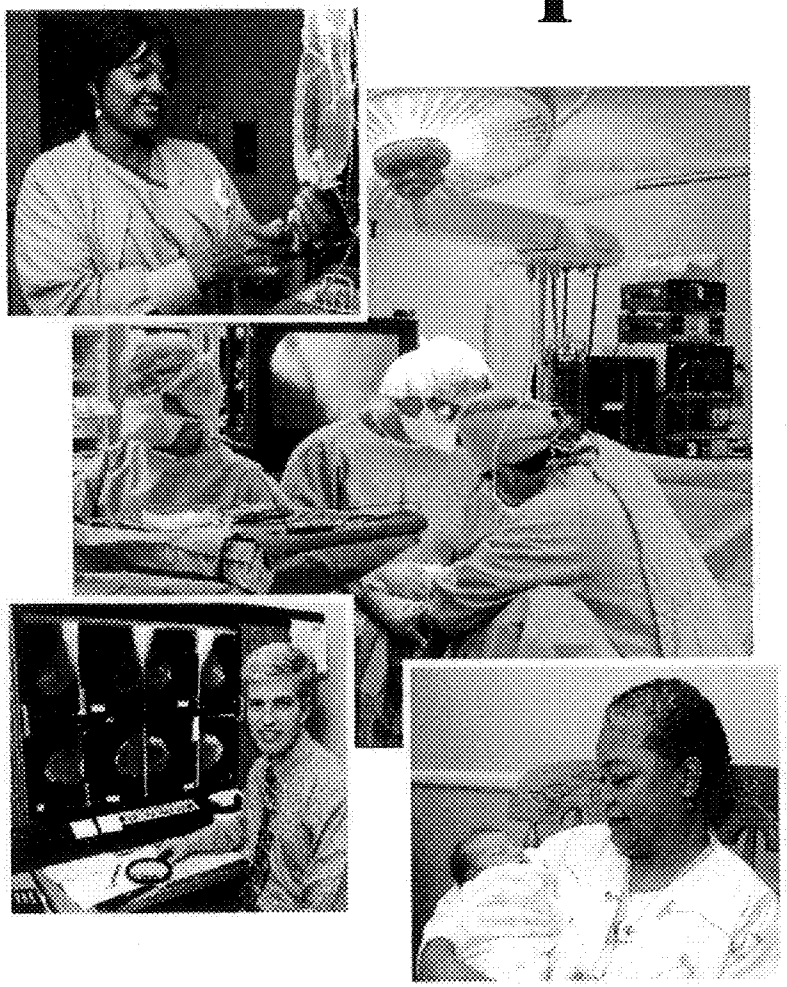
KENDALL REGIONAL MEDICAL CENTER

IS COMMITTED TO PROVIDING A SAFE ENVIRONMENT FOR OUR PATIENTS !!!!



Baptist Health Care

Quality and Patient Safety at Baptist Health Care



-100K Lives Campaign-

January 11, 2006

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Quality as a Strategy

2001 - 2004

People

- **Recruit & retain top industry talent**

Service

- **Enhance physician relations with BHC**

Quality

- **Improve clinical outcome for consistent high quality of care**
- **Develop/enhance clinical programs in profitable Centers of Excellence**

Quality as a Strategy

2001-2004

Financial

- **Decrease unit operating cost**

Growth

- **Explore and pursue alternative revenue streams**
- **Identify and address key physician needs**

Performance Improvement Initiatives

- **Patient Safety**
  - **Restraint Usage**
  - **Infection Control**
    - **Ventilator-Related Pneumonia**
    - **Central Line-Related Blood Stream Infections**
    - **Catheter-Related UTI**
  - **Hospital Acquired Pressure Ulcers**
  - **Medication Events**
  - **DVT Safety Initiative (Hospital-Wide DVT/PE prophylaxis and DT prophylaxis)**

Performance Improvement Initiatives

- CMS and JCAHO (7th Scope of Work / Core Measures)
  - **Heart Attack Care**
  - **Heart Failure Care**
  - **Pneumonia Care**
- Hospitalist Initiative
- IHI – SINU Collaborative
- Clinical Accountability Report of Excellence (CARE)
- Women's Heart Advantage
- Centers of Excellence

100K Lives

- Improved care for Acute Myocardial Infarction
- Prevention of Adverse Drug Events
- Prevention of Central Line Associated Blood Stream Infections
- Prevention of Surgical Site Infection
- Prevention of Ventilator-Associated Pneumonia
- Rapid Response Team

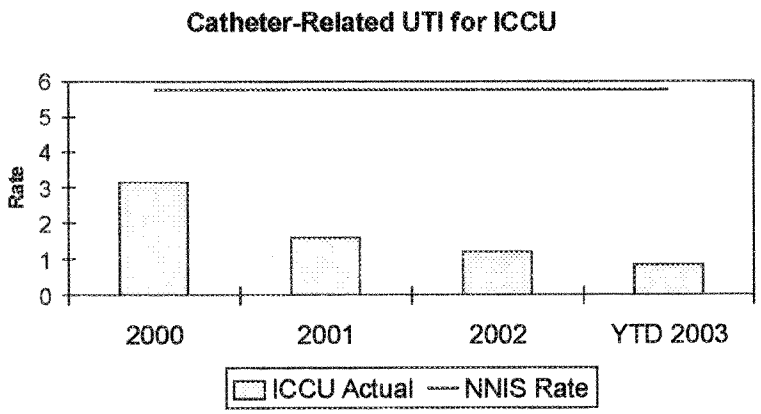
Quality Outcomes

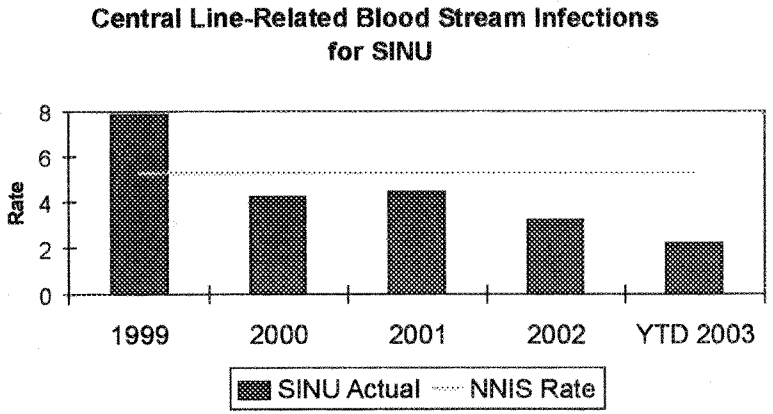
➢Heart Attack Care (10/05)

- **Early administration of aspirin - favorable**
  - ➢**100% v. JCAHO standard score of 94.8%**
- **Ace inhibitor for low LVEF – favorable**
  - ➢**95% v. JCAHO standard score of 79.1%**
- **Documentation of smoking cessation counseling provided during hospitalization – favorable**
  - ➢**100% v. JCAHO standard score of 83.2%**
- **Timely reperfusion of Angioplasty – favorable**
  - ➢**132 min. v. JCAHO standard 288.8 min**

Baptist Hospital, Inc.

Infection Control Results

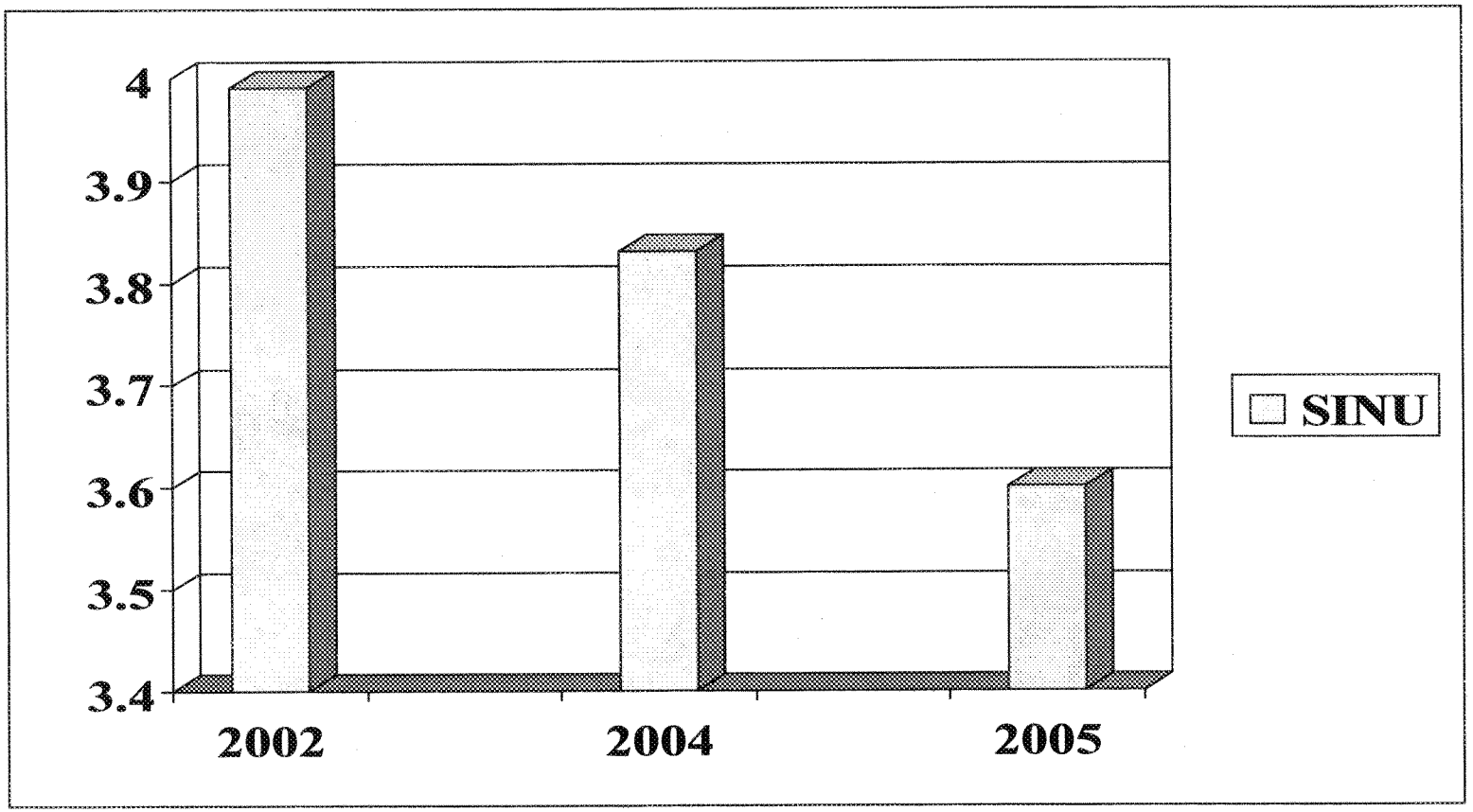




Cost = Approx. $3,800 per Incidence

Total: $57,000 savings

Infection Prevention Results SINU Ventilator –Related Pneumonia



$100,000/yr. Cost-avoidance (at $20K/VAP)

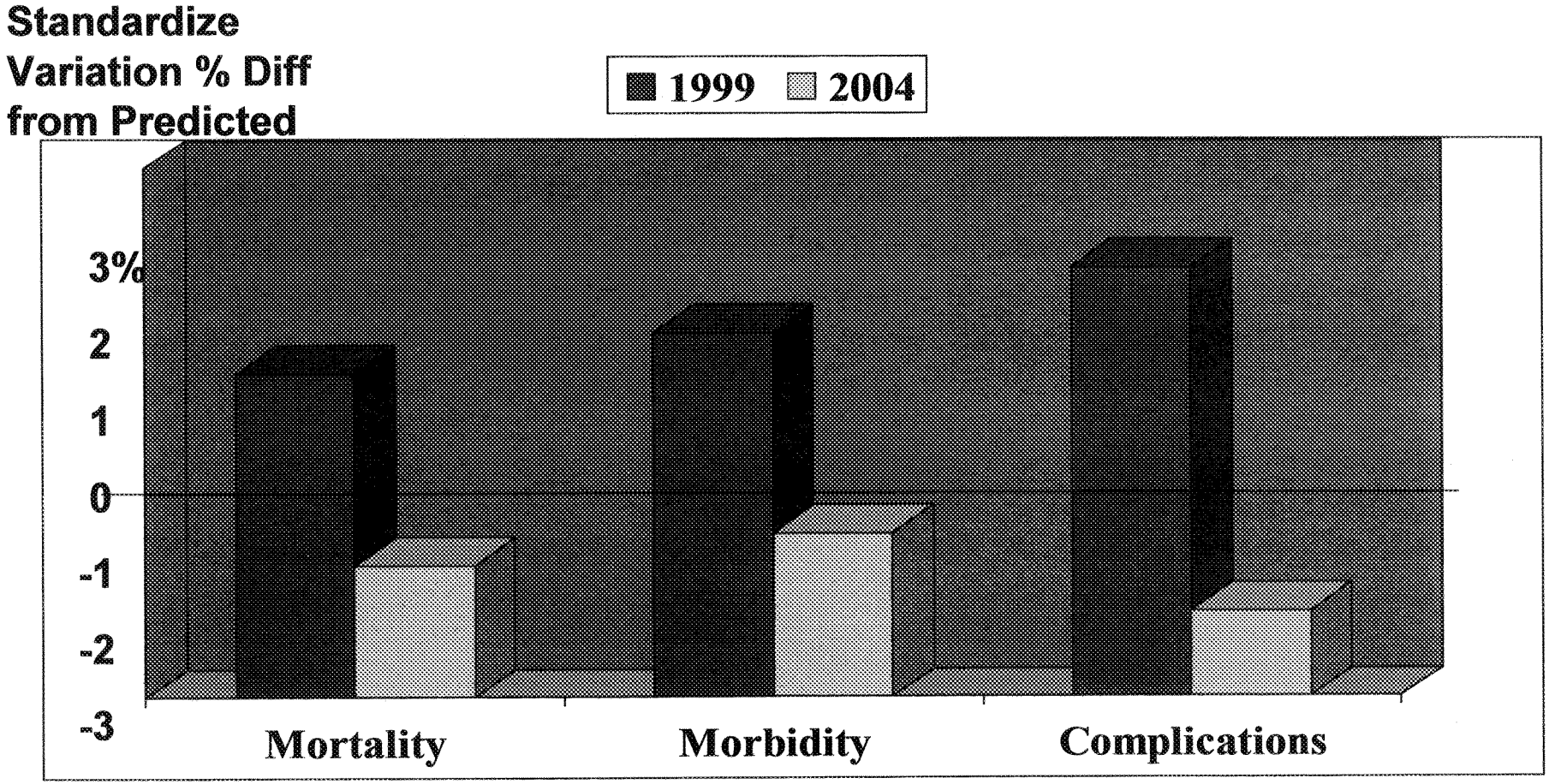
Rapid Response Team

- **A Designated Team**
  - **Critical Care Nurse**
  - **Respiratory Therapist**
  - **Physician (if available)**
- **Responds to clinical deterioration or care giver concerns for patients outside the ICU**
- **Alert the attending physician of problems, initiate diagnostics and treatments, including transfers to ICU or changing code status as designated by protocol.**

Rapid Response Teams
VHA Southeast Report

Indicator	Current Month	Current Quarter	Inception to Date
Total Number of Inpatient Cases	42,741	133, 313	1,068,723
Total Number of RRT Team Calls	379	1,150	1,685
Mortalities per 1,000 Discharges	19.4	19.7	23.6
Utilization of RRT per 1,000 Discharges	8.9	8.6	1.6
Codes per 1,000 Discharges	6.0	6.6	6.9
Codes Outside ICU per 1,000 Discharges	2.8	3.1	3.3
Percent of Codes Outside ICU	47.3%	47.6%	47.9%
Percent of Codes that returned to Spontaneous Circulation	53.3%	54.1%	52.7%
Percent of Codes that Survived Until Discharge	25.9%	26.0%	24.3%

Outcome Profile at Baptist Hospital



Yr. 1999-2000: 12,253 IP Case **Case Mix Index: 1.62**

Yr. 2003-2004: 16,054 IP Case **Case Mix Index: 1.72**

Significant at 90% confidence level

What that means to our patients! 10/1/03 - 9/30/04

- **Mortality**
  - **240 lives saved (would have died elsewhere - predicted by millions of similar patients/conditions nationally)**
- **Morbidity**
  - **192 patients avoided additional illnesses (vent. assoc. pneumonia, blood stream infections, urinary tract infections, etc.)**
- **Complications**
  - **692 patients avoided predicted complications as a result of their procedure, treatment, and/or hospital stay**

Conclusion

"In times of change the learner will inherit the earth while the learned find themselves wonderfully equipped to live in a world that no longer exists."

Eric Hoffer (1902-83)